

II. Session Instructions

Family Education Sessions Overview

Session Number	Session Title	Type of Session	Content	Pages
1	Triggers and Cravings	PowerPoint presentation	Participants learn about the chemical basis of pleasure and reward in the brain and how triggers and cravings relate to addiction.	13–20
2	Alcohol and Recovery	PowerPoint presentation	Participants learn about the nature and prevalence of alcohol use, including the dangers it poses to health and recovery.	21–29
3	Recovery	Panel presentation	Participants learn about the benefits and challenges of recovery from others in recovery. Participants also learn about 12-Step programs and mutual-help groups.	30
4	Methamphetamine and Cocaine	PowerPoint presentation	Participants learn about the nature and prevalence of methamphetamine and cocaine, including the dangers they pose to health and recovery.	31–42
5	Roadmap for Recovery	PowerPoint presentation	Participants learn what relapse risks they will face in each of the four stages of recovery.	43–55
6	Coping With the Possibility of a Relapse	Multifamily group discussion	Participants explore feelings and needs of one another with respect to relapse and learn strategies for coping with relapse.	56–57
7	Opioids and Club Drugs	PowerPoint presentation	Participants learn about the nature and prevalence of heroin and club drugs. They also learn about the dangers to health and recovery posed by heroin, GHB, Rohypnol, LSD, and ecstasy.	58–66
8	Families in Recovery	PowerPoint presentation	Participants learn about the process of recovery and how they can work together to avoid relapse.	67–76
9	Rebuilding Trust	Multifamily group discussion	Participants explore the important role that trust plays in recovery and how they can begin to repair damaged relationships.	77

Session Number	Session Title	Type of Session	Content	Pages
10	Marijuana	PowerPoint presentation	Participants learn about the nature and prevalence of marijuana, including the dangers it poses to health and recovery.	78–82
11	Living With an Addiction	Multifamily group discussion	Participants explore the ways in which recovery can affect family life and discuss challenges and strategies.	84
12	Communication Traps	Multifamily group discussion	Participants explore the important role that communication plays in healthy relationships and about the problems that can hamper communication.	85–88

Session 1: Triggers and Cravings (PowerPoint Presentation)

Overview

Goals of Session

- Help participants understand the relationship between the pleasure and reward system in the brain and addiction.
- Help participants identify the process of addiction.
- Help participants understand the development and progression of craving.
- Help participants recognize the relationship of triggers to craving.
- Help participants develop ways to address triggers and cravings.

Handouts

- FE 1A—A Definition of Addiction: American Society of Addiction Medicine
- FE 1B—Thought Stopping

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 14 through 20 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from www.kap.samhsa.gov by clicking on Products, clicking on Resource Documents & Manuals, and then clicking on the Matrix icon.

Slide 1-1—Triggers and Cravings

- This presentation begins with an overview of addiction and dependence and then focuses on the development of addiction and cravings and the relationship of environmental and internal triggers for craving.
- Understanding this process allows both clients and families to view substance use disorders in a new, more understandable way and to see what is behind much of the advice given to clients in treatment.
- In short, triggers lead to cravings, and cravings lead to using drugs or drinking alcohol.
- Common sense suggests that being around people, places, or situations that have resulted in past substance use can increase the chances of using or drinking again.
- The influence that triggers have on the brain makes the advice to avoid triggers more than just a good idea; there is no other reliable way to avoid cravings and relapse.

Slide 1-2—Changes in the Brain

- Addiction is a neurobehavioral disorder. To understand what this means, we must look at two important areas of the brain: the prefrontal cortex and the limbic system.
- In a healthy brain, the prefrontal cortex, or outside portion of the brain, is responsible for rational thinking. It is the decisionmaker, the onboard computer of the human being.
- Underneath the cortex is a much older, more primitive part of the brain's anatomy, the limbic system.
- To a greater or lesser degree this lower part of the brain is involved in all forms of addiction. It is where the pleasure and reward system is located and where most, if not all, survival mechanisms originate.
- Pleasure is a powerful biological force for survival. If you do something pleasurable, the brain is wired in such a way that you tend to do it again.
- Unlike the cortex, the limbic system is not under conscious, or voluntary, control. The powerful effects of drugs and alcohol on this and other parts of the brain can lead to addictive use, lessening normal, rational restraints on behavior.
- Prolonged drug use changes the brain in fundamental and long-lasting ways. These changes are a major component of the addiction itself.
- Accepting addiction as a complicated relationship between the brain and behavior is a step toward recovery.

Slide 1-3—Conditioning

- The part of the brain affected by mood-altering substances is the same part of the brain that makes us seek food when we are hungry and water when we are thirsty and is responsible for our sexual drive.

- Hunger, thirst, sexual desire, and the need for nurturing are natural cravings. Satisfying these cravings promotes our survival as individuals and as a species. When a craving is not satisfied (e.g., when a person has not eaten for a long time), satisfying the craving overpowers all other concerns.
- When long-term drug or alcohol use occurs, the brain can become rewired and adapt to these substances as if survival depends on them.
- There is a demonstration that reflects the power of drugs on the brain and behavior:
 - ♦ If you release a caged mouse and it has the option to run into a well-lighted area or a dark area, it always will run into the dark.
 - ♦ Mice and other small rodents have been conditioned to seek out the dark automatically, because darkness protects them from predators. This ingrained survival mechanism evolved over millions of years in this species.
 - ♦ If the mouse is given doses of cocaine in the lighted area, the mouse will go into the lighted area each time it is released from its cage. This classic experiment demonstrates “conditioned place preference,” reversing the conditioning that took place over millions of years.

Slide 1-4—Pavlov

- To understand the relationship of triggers to craving, it is important to understand a bit about a process called conditioning.
- I.P. Pavlov, a Russian scientist, received the Nobel Prize for a series of experiments he conducted on the physical processes of digestion.
- These experiments were continued by some of his students, and the conclusions from these experiments became known as the principles of classical conditioning.

Slide 1-5—Pavlov’s Dog

- Pavlov would feed the dogs and ring a bell at the same time.
- The dogs saw and smelled the food that then stimulated, or triggered, a part of their brain, causing them to produce saliva and secrete stomach acid in anticipation of eating.
- In a relatively short time, Pavlov and his colleagues rang the bell *without* the presence of food, and the dogs still produced saliva and stomach acid as if food were present.
- The dogs connected the sound of the bell, the **trigger**, with anticipation of eating and responded (involuntarily) physically to the powerful trigger, or stimulus, of the bell.
- Once a dog had been conditioned in this way, no matter how smart or well trained the dog was, it continued to produce fluids at the sound of the bell. It had no choice; the only way that Pavlov’s dogs could avoid drooling was by avoiding the bell.
- The dogs had developed a conditioned response to the bell.
- The human brain responds in much the same way to conditioned drug and alcohol triggers that produce cravings.

- Drugs and alcohol produce changes in the brain, which result in feelings of pleasure. Events that people experience or surroundings that people are in when they use are like Pavlov's bell; they cause people to experience cravings (like the dogs' physical response to the bell, salivating) even when they are not using. The brain may even trigger physical reactions that are similar to those initially created by the drug itself.
- For example, if participants were to think about sucking on a lemon, they probably would pucker their lips without even meaning to. This response is based on their experiences of tasting a lemon in the past.
- This sort of response to drug triggers occurs regardless of whether a person intends to use. The dependent person can prevent his or her brain's reaction only by avoiding triggers.
- Triggers and cravings are hallmarks of addiction.

Slide 1-6—A Definition of Addiction

- Handout FE 1A provides a definition of addiction developed by the American Society of Addiction Medicine.
- Primary means that addiction is not just a symptom of another disease or disorder; it is a disease in and of itself.
- Chronic means that the disease continues over time and can be treated but not cured. Examples of other chronic diseases include diabetes and heart disease.
- The definition states that genetic, psychosocial, and environmental factors may influence the development and manifestations (symptoms) of the disease.
- "Genetic" means that some people are born with certain susceptibilities to becoming addicted to drugs or alcohol.
- "Psychosocial and environmental factors" means that a person's emotional, mental, and social life as well as his or her family, peers, living situation, employment or school situation, and other life circumstances can affect whether addiction develops and how it develops.
- These psychosocial and environmental factors are important to consider when looking at a person's triggers for drug or alcohol use.

Slide 1-7—The Addictive Process

- The rest of this session looks at the process of developing addiction over time, focusing on craving and the triggering of craving.
- The process of addiction can be looked at in terms of four phases: the introductory phase, the maintenance phase, the disenchantment phase, and the disaster phase.
- During each phase, people experience increasing levels of obsessive thinking, craving responses, use, and consequences resulting from their substance.
- Although the slides are methamphetamine specific, the process of addiction is virtually the same for other addictive drugs and alcohol.

Slide 1-8—Addictive Process (Introductory Phase)

- Methamphetamine (or another drug or alcohol) use is relatively infrequent during the introductory phase of the process of addiction.
- Use may be limited to a few times a year, by chance, or on special occasions.
- The positives of drug or alcohol use appear to outweigh the negatives.

Slide 1-9—Conditioning Process During Addiction (Introductory Phase)

- Unknowingly, persons who use drugs or alcohol are conditioning their brains every time they use, but they experience only a mild association between people, places, or events and drug or alcohol use.

Slide 1-10—Development of Obsessive Thinking (Introductory Phase)

- During this phase, drug or alcohol use is only one small component of a person's overall thought process.

Slide 1-11—Development of Craving Response (Introductory Phase)

- The craving response is the combined experiences of drug or alcohol triggers activating the limbic system and the continuing thoughts about using drugs or alcohol associated with these triggers.
- During this introductory phase, the limbic system is activated *directly* by drugs or alcohol and, depending on whether the substance is a stimulant or a depressant, physiological arousal either increases or decreases (for example, methamphetamine causes the heart and respiration to speed up, whereas heroin causes the heart and respiration to slow down).

Slide 1-12—Addictive Process (Maintenance Phase)

- During the maintenance phase of the addictive process, the frequency of drug or alcohol use increases to perhaps monthly or weekly.
- The scales begin to lean away from the positives.

Slide 1-13—Conditioning Process During Addiction (Maintenance Phase)

- Conditioning is progressing. The people, places, and things associated with drug and alcohol use have become triggers.
- Exposure to these triggers causes thoughts about drug and alcohol use.
- These thoughts produce moderate physiological reactions leading to a drive to find and use drugs and alcohol.

Slide 1-14—Development of Obsessive Thinking (Maintenance Phase)

- Thoughts of drug and alcohol use occur more frequently.

Slide 1-15—Development of Craving Response (Maintenance Phase)

- A mild physiological *arousal* occurs in situations closely associated with drug and alcohol use.
- As the person encounters drug and alcohol triggers, the limbic system is activated, and drug and alcohol cravings occur.
- When drugs and alcohol finally are ingested, a concurrent physiological state occurs.

Slide 1-16—Addictive Process (Disenchantment Phase)

- During the disenchantment phase, the scales tip from the positive to the negative.
- The consequences of drug and alcohol use are severe, and the person's life becomes unmanageable.
- At this point the rational decision is to stop using, but the cortex part of the brain is no longer in control.
- Thinking, evaluating, and decisionmaking may appear to be happening, but behavior is not always based on rational thinking.
- People may resolve sincerely to quit using yet may find themselves out of control at the first thought of drugs and alcohol, at the first encounter with someone they used with, at the availability of cash, or with other potent triggers.

Slide 1-17—Conditioning Process During Addiction (Disenchantment Phase)

- At this point people usually cross the line into addiction, continuing to use in spite of serious negative physical and social consequences.
- Triggers in this phase produce a strong physiological response that drives people to acquire and use drugs and alcohol.

Slide 1-18—Development of Obsessive Thinking (Disenchantment Phase)

- During the disenchantment phase, the frequency of drug and alcohol thinking increases, crowding out most thoughts about other aspects of life.

Slide 1-19—Development of Craving Response (Disenchantment Phase)

- In this phase, the craving response is powerful.
- People feel an overpowering physical reaction in situations further and further removed from drugs or alcohol.
- The craving response is almost as powerful as the actual physical reaction to drugs and alcohol.

Slide 1-20—Addictive Process (Disaster Phase)

- In the disaster phase, the drug and alcohol use is often automatic.
- People cannot restrain themselves from using drugs or alcohol.

- People's behavior in the phase is much like the behavior of addicted laboratory animals that use drugs until they die.

Slide 1-21—Conditioning Process During Addiction (Disaster Phase)

- In this phase, addicted persons are using either daily or in binges, which most likely are interrupted only by physical collapse, hospitalization, or arrest.
- The constant overpowering craving from the limbic system overwhelms the cortex.

Slide 1-22—Development of Obsessive Thinking (Disaster Phase)

- Thoughts of drug and alcohol use dominate the person's consciousness.

Slide 1-23—Development of Craving Response (Disaster Phase)

- In the disaster phase, cravings can create powerful physiological effects that even can begin to mimic the initial physiological effects of actually ingesting the drug.

Slide 1-24—Trigger–Thought–Craving–Use

- Craving can be activated by external triggers.
- Triggers can cause thoughts, which can turn into cravings and lead to use.

Slide 1-25—Interruption

- The earlier this chain of events is interrupted, the more likely relapse will be avoided.
- An effective technique for coping with triggers and cravings is thought stopping.

Slide 1-26—Thought Stopping

- Simply put, thought stopping interrupts the usual process that culminates in using or drinking.
- The usual reaction to thoughts about using “argue” with the developing thought/craving. The argument usually results in the addiction winning.
- Arguing precedes negotiation, compromise, justification, and, possibly, relapse.
- Thought stopping ends this process before relapse begins, usually stopping cravings in their tracks.
- If thought stopping works, but the thoughts frequently keep coming back, people in recovery may have to change their immediate environments or engage in tasks that require full concentration.
- Thought stopping techniques include
 - ♦ Visualization
 - ♦ Relaxation
 - ♦ Rubberband snap
 - ♦ Calling someone

Slide 1-27—Visualization

- When people experience thoughts of using drugs or alcohol, they can visualize a switch or lever and imagine actually moving it from ON to OFF to stop the drug- or alcohol-using thoughts.
- It is important to have another thought ready to replace the drug- or alcohol-using thoughts.
- It should be a pleasurable or meaningful thought and one that does not involve drug or alcohol use.

Slide 1-28—Rubberband Snap

- The rubberband behavioral technique helps people in recovery “snap” their attention away from thoughts of using drugs or alcohol.
- People who are addicted simply put a rubberband loosely around their wrists.
- When a craving or using thought occurs, people snap the rubberband lightly against their wrists and say “NO” (either aloud or not, depending on the situation) to the drug- or alcohol-using thought.
- As with visualization, people need to have another thought ready to replace the drug- and alcohol-using thoughts.
- This technique works best if people leave the rubberband on all the time.

Slide 1-29—Relaxation

- Cravings often create feelings of hollowness, heaviness, and cramping in the stomach.
- These feelings often can be relieved by breathing in deeply (filling the lungs with air) and slowly breathing out three times in a row and by focusing on relaxing the body as much as possible for a few minutes.
- This process can be repeated as often as necessary whenever the feelings return.

Slide 1-30—Calling Someone

- Talking to another person provides an outlet for feelings and allows people to “hear” their own thinking process.
- Recovering people should carry the phone numbers of supportive people with them *always*, so they can call whenever support is needed.
- Handout FE 1B provides a list of thought-stopping suggestions.

Session 2: Alcohol and Recovery (PowerPoint Presentation)

Overview

Goals of Session

- Provide participants with factual information about alcohol.
- Provide participants with information about the risks that alcohol poses to recovery.
- Provide an opportunity for participants to talk about their experiences (or the experiences of their family member) with alcohol and recovery.

Handout

- FE 2—Fact Sheet: Alcohol

PowerPoint Presentation (40–45 minutes)

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Focused Discussion (30 minutes)

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Slide 2-1—Alcohol and Recovery

- This session focuses on alcohol.
- Because alcohol is such a significant and pervasive part of U.S. culture, *not* drinking presents a particular challenge for a person recovering from stimulant dependence.

- People in recovery must understand how alcohol can affect their bodies, behaviors, and recoveries.
- Although many people use alcohol occasionally and without problems, alcohol is a powerful substance that can seriously damage people's bodies and lives.

Slide 2-2—Alcohol in the Brain

- Alcohol affects many chemical systems in the brain.
- A delicate balance exists between chemical systems that *stimulate* and chemical systems that *inhibit*, or slow down, functions of the brain and body.
- Alcohol interferes with and changes this delicate balance.

Slide 2-3—Adaptation

- If people drink alcohol frequently and steadily, their brains adapt over time to the presence of alcohol.
- They do this by producing naturally stimulating chemicals in larger quantities than normal.
- As the brain and body adapt, the person can become dependent on alcohol to maintain a chemical balance.
- If a person who is dependent on alcohol stops drinking all at once, the high level of stimulating chemicals can cause withdrawal symptoms because the depressant effect of alcohol is absent.
- Withdrawal symptoms vary depending on how much alcohol and how long a person has been drinking.

Slide 2-4—Withdrawal Symptoms

- Withdrawal symptoms can include
 - ♦ Seizures
 - ♦ Tremors (shakiness)
 - ♦ Nausea
 - ♦ Auditory or visual hallucinations (hearing or seeing things that aren't there)
 - ♦ Insomnia
 - ♦ Agitation (extreme nervousness and irritability)
 - ♦ Confusion

Slide 2-5—Delirium Tremens

- Alcohol withdrawal can be life-threatening.
- Delirium tremens (DTs) is a dangerous withdrawal condition.
- Without treatment, as many as 1 out of every 20 people who develop its symptoms die.¹
- Symptoms of DTs include
 - ♦ Rapid heart rate
 - ♦ Tremors
 - ♦ Increased body temperature
 - ♦ Loss of ability to control muscle movement

- ♦ Increased blood pressure
- ♦ Abnormally fast breathing
- ♦ Sweating
- ♦ Altered mental status
- ♦ Hallucinations
- ♦ Cardiovascular collapse and death

Slide 2-6—Incidence

- Most people older than 21 can drink moderate amounts of alcohol without developing problems.
- The 2003 National Survey on Drug Use and Health reports that about half of Americans ages 12 and older report drinking alcohol.²
- The National Institute on Alcohol Abuse and Alcoholism estimates that about 3 in 10 (30 percent) American adults drink at levels that increase their risk for physical, emotional, and social problems.³
- Of these heavy drinkers, about one in four currently has an alcohol use or dependence disorder.⁴

Slide 2-7—Incidence by Gender and Age⁵

- In general, more men report being current drinkers than do women: in 2003, 57 percent of men ages 12 and older reported past month alcohol use compared with 43 percent of women.
- The rate of alcohol *dependence* is also lower for women than it is for men.
- Estimates indicate that about one-third of those dependent on alcohol are women.
- The incidence of heavy alcohol use is highest among young adults between ages 21 and 29 and lowest among adults ages 65 and older.

Slide 2-8—Initial Effects of Alcohol

- When people first begin to drink, they experience
 - ♦ Feelings of well-being or euphoria
 - ♦ Talkativeness and increased sociability
 - ♦ Lowered inhibitions (people may do or say things they otherwise would not do or say)

Slide 2-9—Later Effects

- As people continue to drink, they begin to feel sedated and drowsy and may
 - ♦ Have trouble with balance
 - ♦ Experience impaired peripheral vision (the ability to see to the sides)
 - ♦ Experience delayed reaction time
 - ♦ Slur their words
 - ♦ Vomit
 - ♦ Fall asleep
 - ♦ Black out and not remember anything that happened for a period while under the influence

Slide 2-10—Long-Term Effects

- Heavy drinking can cause significant damage to organ systems in the body.
- “Heavy” drinking can be defined as binge drinking on five or more occasions in the past month.
- Binge drinking is drinking five or more drinks on one occasion at least once in the past month.
- When alcohol is consumed, it enters the bloodstream and is distributed throughout the body.
- Although heavy drinking is most commonly associated with liver damage, it also can affect the digestive, cardiovascular, immune, endocrine, and nervous systems.

Slide 2-11—Liver

- The liver is the primary site of alcohol metabolism (breaking down the alcohol into other chemicals and eliminating it from the body), yet a number of the chemicals produced by this process are toxic (poisonous) to the liver itself.
- These toxins add up over time, leading to alcohol-induced liver damage.
- This damage can take the form of either inflammation (alcoholic hepatitis) or scarring (cirrhosis).
- Often both types of damage exist in the same person.
- Alcohol dependence is the leading cause of liver-related deaths in the United States.
- It is estimated that more than 2 million people experience some form of alcoholic liver disease.

Slide 2-12—Digestive System

- Alcohol also affects the digestive system.
- Excessive drinking has been shown to cause chronic inflammation of the esophagus (the passageway to the stomach), which can lead to esophageal cancer.
- Enlarged blood vessels in the esophagus (esophageal varices) can be caused by liver disease.
- These blood vessels can rupture; when this happens, it is often fatal.
- Heavy alcohol use has been linked to pancreatitis (inflammation of the pancreas) and cancers in the throat, colon, and rectum.

Slide 2-13—Cardiovascular System

- Although moderate alcohol intake (one drink per day for women; two drinks for men) has been shown in some studies to be heart protective, heavy alcohol use is associated with serious heart disease:
 - ◆ It interferes with the pumping action of the heart, causing irregular and/or weak heartbeats.
 - ◆ It causes high blood pressure, which can increase the risk of stroke.
- Blood platelets, involved in blood clotting, also are damaged, causing an increased risk of bleeding.

Slide 2-14—Immune System

- Alcohol can seriously affect the body's immune system (the system that protects the body from disease) by damaging white and red blood cells.
- People who drink heavily experience more infectious diseases than do people who drink only moderately.
- Alcohol can damage the immune system to a level where the immune system attacks the body. This can result in, or worsen, alcohol-induced organ damage such as alcoholic liver disease.

Slide 2-15—Endocrine System

- The body's endocrine system (the hormone-controlling system) can be damaged by long-term alcohol use.
- The balance of the hormones insulin and glucagon, which regulate blood sugar levels, is disrupted; diabetes is common among people who drink heavily.
- Drinking alcohol can alter the release of reproductive hormones, growth hormone, and testosterone.
- The effects of alcohol on hormone systems include decreased testicle and ovary size and disrupted sperm and egg production.
- Alcohol-induced changes in hormone concentrations are associated with sexual dysfunction in both men and women.

Slide 2-16—Nervous System

- Heavy use of alcohol may damage the nervous system. This damage may include
 - ◆ Peripheral neuropathy, resulting in numbness and tingling in the legs, arms, and/or hands
 - ◆ Wernicke's syndrome, resulting in disordered eye movements, very poor balance, and difficulty walking
 - ◆ Korsakoff's syndrome, resulting in severely affected memory, preventing new learning from taking place
- In addition to these nervous system disorders, most people who drink heavily have some loss of mental function, reduced brain size, and changes in the function of brain cells.

Slide 2-17—Behavioral Effects

- Drinking can cause behavioral and physical problems.
 - ◆ Alcohol use is associated with domestic violence, child abuse, and assault.
 - ◆ Use is associated with all types of accidents.
 - ◆ The more heavily a person drinks, the greater the potential for problems at home, at work, with friends, and even with strangers. These problems may include

- Arguments with or separation from spouse and other family members
- Strained relationships with colleagues
- Absence from or lateness to work with increasing frequency
- Loss of employment because of decreased productivity
- Committing or being the victim of violence
- Auto crashes and/or arrests for driving under the influence (DUI)

Slide 2-18—Alcohol and Women⁶

- Drinking affects women differently than it affects men:
 - ♦ Over the long term, women develop alcohol-related disease more quickly and after drinking less alcohol than men do.
 - ♦ Women develop alcoholic liver disease more quickly and after drinking less alcohol than men do. Women are more likely than men to develop alcoholic hepatitis (liver inflammation) and to die from cirrhosis.
 - ♦ Women are more vulnerable than men to alcohol-induced brain damage.
 - ♦ Among people who drink heavily, men and women have similar rates of alcohol-related heart disease, even though women drink less alcohol over a lifetime than men do.
- For some women, even moderate drinking can slightly raise the risk of breast cancer.

Slide 2-19—Alcohol and Pregnancy

- A woman who drinks when she is pregnant puts her baby at risk of serious problems.
- Babies born to mothers who drank during pregnancy may have mental retardation or other learning and behavioral problems.
- Research has not found *any* amount of alcohol to be safe during pregnancy.

Slide 2-20—Fetal Alcohol Spectrum Disorders

- The most serious risk is fetal alcohol spectrum disorders (FASD).
- FASD is the leading known cause of preventable mental retardation in the United States.⁷

Slide 2-21—Fetal Alcohol Spectrum Disorders (Cognitive and Behavioral Impairments)⁸

- Although the effects of FASD vary, children with the syndrome have cognitive and behavioral impairments.
- Behavioral and neurological problems associated with FASD may lead to poor academic performance and legal and employment difficulties in adolescence and adulthood.

Slide 2-22—Fetal Alcohol Spectrum Disorders (Craniofacial Features)

- Children with severe FASD usually have distinctive facial and head features, such as
 - ♦ Skin folds at the corner of the eyes
 - ♦ A small head circumference
 - ♦ A low nasal bridge
 - ♦ A small eye opening
 - ♦ A short nose
 - ♦ A small midface
 - ♦ An indistinct philtrum (the groove between the nose and upper lip)
 - ♦ A thin upper lip

Slide 2-23—Total Abstinence

- Heavy alcohol use has obvious damaging effects.
- However, occasional, light drinking can have a damaging effect on a person in recovery, even if the person has never experienced any problems with alcohol.
- Clients in Matrix treatment are asked to stop using all illicit drugs *and* alcohol, no matter what drug or drugs brought them into treatment.

Slide 2-24—Alcohol Triggers Are Everywhere

- A person in recovery who is trying to stop using alcohol faces a difficult struggle.
- External triggers bombard people in recovery; consumption of alcohol may be assumed to be the norm, especially at social functions and celebrations.
- Drinking often accompanies certain activities: wine with dinner, a beer at the game, a drink after work.
- It is hard for a person in recovery to go through a typical day without coming across many reminders—both cultural and personal—of alcohol.
- Advertisements, movies, and TV shows link drinking with being happy, popular, and successful.
- Recovering people encounter colleagues, friends, and family members with whom they used to drink and pass by bars or liquor stores that they used to frequent.
- Alcohol is integral to celebrations such as parties and weddings.
- A person in recovery who is not drinking may feel left out of the fun or less cool.

Slide 2-25—Internal Triggers

- Internal triggers also pose problems:
 - ♦ Depression, anxiety, and loneliness are all characteristic of recovery.
 - ♦ These emotional states and others, such as stress, anger, and guilt, are cues to drink for many people.

- ♦ Facing the emotional fallout from quitting other substances, people in recovery may feel justified in turning to alcohol to “relieve” their mental state.

Slide 2-26—Relapse Warning

- However, in spite of the difficulty, it is critical that people recovering from stimulant dependence abstain from alcohol.
- One big reason for this is that studies show that people who use stimulants are *eight times* more likely to relapse to stimulant use if they use alcohol than if they don't drink.⁹

Slide 2-27—Relapse

- Drinking lowers a person's inhibitions and makes the person more likely to act impulsively on any using thoughts they may have.
- Because alcohol affects the rational, reasoning part of the brain, people who are drinking are ill equipped to cope with any triggers for stimulant use they encounter.
- In addition, people who are drinking are more likely to encounter triggers than are individuals who are not drinking. For example, drinking may
 - ♦ Put people in recovery into contact with other people who use stimulants
 - ♦ Put people in recovery into a “party” atmosphere that can trigger the desire to use stimulants
 - ♦ Trigger a desire for the stimulant high

Slide 2-28—Other Reasons for Abstaining

- There are other reasons for abstaining from alcohol. When people are learning to handle problems without resorting to stimulants, using alcohol to numb the uncomfortable learning process is counterproductive for two reasons:
 - ♦ Drinking alcohol prevents people from directly confronting their stimulant use problem.
 - ♦ Drinking puts people in recovery at risk of becoming dependent on alcohol while they are trying to overcome their dependence on stimulants.

Slide 2-29—Plan Not To Drink

- It is important for people in recovery to *plan* not to drink, rather than wait until they are confronted with a trigger or urge to drink. For example, people in recovery can
 - ♦ Think about other ways of celebrating
 - ♦ Avoid being around others who are drinking
 - ♦ Think about ways of spending time with friends that don't involve alcohol
 - ♦ Make friends with others who are in recovery

- ♦ Practice saying “no thank you”
- ♦ Avoid going to bars and parties
- ♦ Ask family members not to drink in their presence or keep alcohol in the house

Slide 2-30—Plan To Cope

- A person in recovery should develop a plan for coping with the uncomfortable feelings that arise during recovery. This plan could include
 - ♦ Regularly attending 12-Step or mutual-help group meetings
 - ♦ Discussing feelings openly in Matrix group sessions
 - ♦ Obtaining a 12-Step sponsor
 - ♦ Regularly practicing relaxation techniques
 - ♦ Practicing HALT (not becoming too hungry, angry, lonely, or tired)
 - ♦ Developing a way to remember that uncomfortable feelings are normal in recovery and will pass
 - ♦ Obtaining help from a therapist if feelings become too overwhelming
- Handout FE 2—Fact Sheet: Alcohol summarizes the information presented in this session.

1 Tevisan, L.; Boutros, N.; Petrakis, I.; and Krystal, J.H. Complications of alcohol withdrawal. *Alcohol Health and Research World* 22(1):61–66, 1998.

2 Substance Abuse and Mental Health Services Administration (SAMHSA). *Results From the 2003 National Survey on Drug Use and Health: National Findings*. NSDUH Series H-25, DHHS Publication No. (SMA) 04-3964. Rockville, MD: Office of Applied Studies, SAMHSA, 2004.

3 National Institute on Alcohol Abuse and Alcoholism. *Helping Patients Who Drink Too Much: A Clinician's Guide*, 2005 Edition. Bethesda, MD: National Institutes of Health, 2005. www.niaaa.nih.gov/publications/Practitioner/guide.pdf [accessed September 16, 2005].

4 See note 3.

5 See note 2.

6 National Institute on Alcohol Abuse and Alcoholism. Are women more vulnerable to alcohol's effects? *Alcohol Alert* 46, December 1999 (updated October 2000). www.niaaa.nih.gov/publications/aa46.htm [accessed September 16, 2005].

7 National Institute on Alcohol Abuse and Alcoholism. Fetal alcohol exposure and the brain. *Alcohol Alert* 50, December 2000 (updated April 2001). www.niaaa.nih.gov/publications/aa50.htm [accessed September 16, 2005].

8 See note 7.

9 Rawson, R.A.; Shoptaw, S.J.; Obert, J.L.; McCann, M.J.; Hasson, A.L.; Marinelli-Casey, P.J.; Brethen, P.R.; and Ling, W. An intensive outpatient approach for cocaine abuse treatment: The Matrix model. *Journal of Substance Abuse Treatment* 12(2):117–127, 1995.

Session 3: Recovery (Panel Presentation)

Goals of Session

- Provide an opportunity for participants to hear stories of successful recovery.
- Provide an opportunity for participants to ask questions of individuals in recovery.
- Provide important information about the recovery process in a personal way that engages participants.

Handouts

- FE 3A—Guidelines for Graduate Panel Participants
- FE 3B—Guidelines for Family Member Panel Participants
- FE 3C—Guidelines for Recovery Panel Participants

Preparation

At least 1 week before the session, the counselor identifies, invites, and orients four or five panel participants. The panel should comprise a mix of program graduates who are stable in their recovery and actively involved in a 12-Step program or mutual-help group and family members of program graduates who are working on their own program of recovery in Al-Anon or a mutual-help group. If the counselor is unable to identify appropriate graduates, he or she should contact the local Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) Intergroup Office's Hospitals and Institutions or Treatment Facilities Committee for help in identifying local individuals who are in recovery and would be willing to participate on the panel.

The counselor ensures that graduate panel participants receive a copy of handout FE 3A—Guidelines for Graduate Panel Participants and that family member panel participants receive a copy of handout FE 3B—Guidelines for Family Member Panel Participants before the session. If the counselor is using AA or NA members, the counselor should give these participants a copy of FE 3C—Guidelines for Recovery Panel Participants as they arrive at the facility.

Just before the session, the counselor should remind panel participants that they will have about 10 minutes to tell their stories, using the guidelines listed on the handouts.

Presentation (45 minutes)

The counselor introduces panel participants and facilitates each presentation to ensure that each participant stays on track and does not take too much time. The counselor may ask a panel member a question from the handouts if he or she seems to be having difficulty staying on topic. The counselor should have extra copies of the handouts available for panel participants to refer to as needed.

Question-and-Answer Period (30 minutes)

The counselor encourages group members to ask questions of panel participants and facilitates discussion. When the discussion winds down, the counselor thanks panel members and dismisses them.

Open Discussion (15 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Session 4: Methamphetamine and Cocaine (PowerPoint Presentation)

Overview

Goals of Session

- Provide factual information about how methamphetamine and cocaine act in the brain.
- Provide factual information about the psychological and physical effects of methamphetamine.
- Provide factual information about the psychological and physical effects of cocaine.
- Provide an opportunity for participants to talk about the effects stimulant drugs have had on them or their family member.

Handouts

- FE 4A—Fact Sheet: Methamphetamine
- FE 4B—Fact Sheet: Cocaine

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 32 through 42 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

The counselor may want to break the discussion into two parts, stopping between the presentation on methamphetamine (slides 4-10–4-28) and the presentation on cocaine (slides 4-29–4-44).

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from www.kap.samhsa.gov by clicking on Products, clicking on Resource Documents & Manuals, and then clicking on the Matrix icon.

Slide 4-1—Methamphetamine and Cocaine

- This session focuses on methamphetamine (meth) and cocaine.
- Both are highly addictive stimulant drugs that are similar in many ways, although there are significant differences as well.

Slide 4-2—Differences Between Cocaine and Methamphetamine

- Cocaine and methamphetamine differ in that cocaine is processed out of the body much faster than is methamphetamine, so the effects, or high, of cocaine don't last as long.
- The effects of cocaine last for only 1 to 2 hours, whereas the effects of methamphetamine last 8 to 12 hours.
- Withdrawal from methamphetamine also can last longer, and the symptoms of withdrawal may be more intense than those of cocaine withdrawal.

Slide 4-3—Dopamine

- The effects of both meth and cocaine are caused by the drugs' effects on *dopamine*, a chemical that is always present in the brain.
- Dopamine plays an important role in
 - ♦ Body movement
 - ♦ Thinking
 - ♦ Motivation and reward
 - ♦ Pleasure responses
- Dopamine also plays an important role in addiction to any drug.

Slide 4-4—Example of Dopamine's Effect

- When a person engages in natural activities like eating, drinking, and sex, dopamine is released by cells in the brain and creates immediate (though short-lasting) feelings of pleasure by stimulating other cells in the brain.
- These feelings reward the basic activities of eating, drinking, and sex and motivate people to repeat them, ensuring survival.

Slide 4-5—Dopamine Imbalance

- When the natural balance of dopamine is upset (by a drug, for example), a person can experience negative effects:
 - ♦ Too *much* dopamine may produce nervousness, irritability, aggressiveness, fears that are not based on reality, and bizarre thoughts.
 - ♦ Too *little* dopamine is associated with low mood, fatigue, and the tremors and the inability to control movement that is part of Parkinson's disease.

Slide 4-6—Dopamine and Stimulant Drugs

- When a person uses meth or cocaine, too much dopamine becomes available in the brain.
- Although each drug increases the amount of dopamine in the brain in a different way, many of the effects are the same.
- When a person first starts taking meth or cocaine, he or she will experience primarily pleasurable effects but will also experience some negative effects that are caused by too much dopamine.

Slide 4-7—Dopamine and Stimulant Use Over Time

- As a person continues to use meth or cocaine, the brain's dopamine system becomes damaged.
- As the damage increases, the person will continue to experience some pleasurable effects but also will experience substantial negative effects from meth or cocaine.

Slide 4-8—Use–Depression–Craving–Use

- When the stimulant and euphoric effects of meth or cocaine wear off, dopamine levels may decrease to levels that are below normal, and the person experiences an abrupt drop in mood and energy levels.
- Symptoms of fatigue and depression are common.
- These negative feelings often create a strong desire (craving) in the person to take the drug again.
- Over time (often, very little time), this use–depression–craving–use cycle leads to addiction.

Slide 4-9—Route of Administration

- How a drug is taken influences
 - ♦ How quickly it produces an effect
 - ♦ The strength of the drug's effects, both positive and negative
 - ♦ The negative effects a person will experience
- Both meth and cocaine are available in various forms that can be
 - ♦ Injected
 - ♦ Smoked
 - ♦ Snorted

Slide 4-10—Methamphetamine

- The first stimulant drug we will discuss is meth, a synthetic drug that is manufactured from common chemicals.

Slide 4-11—Street Names

- Methamphetamine is known on the street as
 - ♦ Meth
 - ♦ Ice
 - ♦ Glass
 - ♦ Crank
 - ♦ Crystal
 - ♦ Speed
 - ♦ Chalk
 - ♦ Tweak

Slide 4-12—Popularity of Meth¹

- The 2004 National Survey on Drug Use and Health (NSDUH) estimated that 12 million people ages 12 and older had used meth at least once in their lifetime.
- Some evidence shows that meth use has stabilized. The number of people using meth and the number of people trying it for the first time remained constant in 2002, 2003, and 2004.
- From 2002 to 2004, the average age of first use increased by more than 3 years, from 18.9 years to 22.1 years.

Slide 4-13—Who Uses Meth?

- Although the overall rate of meth use may not be increasing, use remains a significant problem.^{2,3}
- The number of people dependent on meth more than doubled between 2002 and 2004.⁴
- Once confined to certain areas of the country, particularly Hawaii and west coast cities, meth use has spread throughout the country and among different populations.⁵
- People who use meth have traditionally been Caucasian, male, blue-collar workers.
- Meth use spread to the party and club scene (raves, etc.).
- Meth use is increasing among Hispanics and young people who are homeless.
- Use among women has increased.
- More women use meth than use cocaine or heroin; near-equal numbers of men and women now use the drug.
- Meth is used increasingly in the workplace; it has long been used by long-haul truck drivers, but use is spreading on construction sites and in manufacturing.
- People in the entertainment, sales, retail, and legal professions also increasingly are using meth.

Slide 4-14—Immediate Psychological Effects

- The immediate *psychological* effects of methamphetamine include
 - ♦ Euphoria
 - ♦ Alertness or wakefulness

- ♦ Feelings of increased strength and renewed energy
- ♦ Feelings of invulnerability (feeling that nothing bad can happen to you)
- ♦ Feelings of increased confidence and competence
- ♦ Intensified feelings of sexual desire
- ♦ Decreased feelings of boredom, loneliness, and shyness

Slide 4-15—Immediate Physical Effects

- The immediate *physical* effects of methamphetamine include

- ♦ Increased
 - Heart rate
 - Pupil size
 - Sensitivity to sound and stimulation
 - Blood pressure
 - Breathing rate
 - Body temperature
- ♦ Decreased
 - Appetite
 - Reaction time
 - Sleep

Slide 4-16—Toxic Effects

- These effects may not sound bad, or they even may sound desirable.
- However, meth can cause serious long-term psychological and physical damage (toxic effects).
- Although many toxic effects go away in time, even after a person stops using meth, some effects can be permanent.
- Most negative effects begin fairly soon with regular meth use.

Slide 4-17—Chronic Psychological Effects

- Chronic *psychological* effects (“chronic” means that these effects may begin later in a person’s use cycle and last a long time) of meth use include increased
 - ♦ Confusion
 - ♦ Loss of ability to concentrate and organize information
 - ♦ Loss of ability to feel pleasure without the drug
 - ♦ Paranoia (persistent feelings that one is being watched, is being followed, or is about to be harmed)
 - ♦ Insomnia and fatigue
 - ♦ Mood swings
 - ♦ Irritability and anger
 - ♦ Depression
 - ♦ Anxiety and panic disorder
 - ♦ Depression when *not* using meth, called “crashing”
 - ♦ Reckless, unprotected sexual behavior

Slide 4-18—Severe Psychological Effects

- Particularly severe *psychological* effects can include
 - ♦ *Tactile* hallucinations (the person feels as if things are crawling on him or her) or *auditory* hallucinations (the person hears things that aren't there)
 - ♦ Severe depression that can lead to suicidal thoughts or attempts
 - ♦ Episodes of sudden, violent behavior
 - ♦ Severe memory loss that may be permanent

Slide 4-19—Chronic Physical Effects

- Chronic *physical* effects of use include
 - ♦ Tremor (shakiness)
 - ♦ Weakness
 - ♦ Dry mouth
 - ♦ Weight loss and malnutrition
 - ♦ Increased sweating
 - ♦ Oily skin
 - ♦ Sores caused by oily skin and by the person picking at his or her skin, a common effect of meth use
 - ♦ Headaches
 - ♦ Severe problems with teeth and gums caused by teeth grinding, decreased blood flow to the mouth, and decreased saliva

Slide 4-20—Severe Physical Effects

- Particularly severe *physical* effects can include
 - ♦ Seizures
 - ♦ Damage to small blood vessels in the brain, which can lead to stroke
 - ♦ Damaged brain cells
 - ♦ Irregular heartbeat that can cause sudden death
 - ♦ Heart attack or chronic heart problems, including the breaking down of the heart muscle
 - ♦ Kidney failure
 - ♦ Liver failure
 - ♦ “Tweaking,” movements that a person can't control that are repeated regularly
 - ♦ Infected skin sores that can cause severe scarring

Slide 4-21—Meth Is Not Just Meth

- Because meth is manufactured by amateur “cooks,” it is often full of impurities, such as lead acetate or mercury, which can lead to heavy metal poisoning, and various acids created in the process.
- In addition, meth is “cut,” or diluted, before it is sold to maximize profits.

- The substances used to cut meth can cause problems of their own.
- Meth purity tends to range from 40 to 70 percent, meaning 30 to 60 percent of what a person injects, snorts, or smokes is *not* meth.⁶

Slide 4-22—Injecting Meth

- The ways in which a person can take meth create special problems as well. *Injecting* meth can cause
 - ♦ Blood clots
 - ♦ Skin abscesses
 - ♦ HIV, tuberculosis, or hepatitis C virus exposure from sharing needles and other works or from unprotected sex
 - ♦ Heart inflammation
 - ♦ Pneumonia
 - ♦ Kidney failure

Slide 4-23—Snorting Meth

- *Snorting* meth can cause
 - ♦ Sinus infection
 - ♦ Holes in the septum, the cartilage between nostrils
 - ♦ Hoarseness
 - ♦ Nosebleeds

Slide 4-24—Smoking Meth

- *Smoking* meth can cause
 - ♦ Throat problems
 - ♦ Burned lips
 - ♦ Lung congestion
 - ♦ Severe coughing with black mucus
 - ♦ Chronic lung disease

Slide 4-25—Meth Dose and Effects

- The dose and frequency of meth use affect the level of toxic effects, as well.
- The higher the dose and the more frequent the use, the higher the likelihood of toxic effects.
- People who use meth tend to develop *tolerance* for the drug, meaning that it takes a higher dose to get the desired effect as people continue to use meth.

Slide 4-26—Pregnancy and Meth

- A woman who uses meth while she is pregnant may harm her fetus.
- Fetuses of mothers who use meth are at higher risk of having a stroke or brain hemorrhage, often causing death, before delivery.

- Meth use during pregnancy also can cause premature birth.
- Fetuses also may be exposed to HIV or hepatitis if the mother is infected with these viruses.
- Babies of mothers who used meth during pregnancy may have
 - ♦ Abnormal reflexes
 - ♦ Trouble eating and digesting food
 - ♦ Extreme irritability

Slide 4-27—Other Effects on Children

- Children are affected by meth in other ways:
 - ♦ Although increasing amounts of meth are being imported from Mexico, home-based labs for making meth remain common in the United States; often children are in these homes.
 - ♦ When children live with parents who manufacture meth, the children are exposed to toxic chemicals used in the process.
 - ♦ Meth labs are dangerous places for children and adults.
 - ♦ Fires, explosions, chemical spills, and toxic fumes are common.
 - ♦ The chemicals used to make meth give off fumes that are strong enough to burn lungs; can damage the brain, kidneys, or liver; and even can be fatal.
 - ♦ Children of people who use meth may be neglected or abused.
 - ♦ In 2001, 700 children who were present in meth labs that were raided by the Drug Enforcement Administration tested positive for toxic chemicals.⁷

Slide 4-28—Other Problems With Meth Labs

- Labs where meth is made cause serious problems for other people and for the environment:
 - ♦ Toxic fumes released from the chemicals used to make meth go into the walls and carpets and remain there for a very long time, putting everyone in the house at risk.
 - ♦ Even people moving into a home that once housed a meth lab are at risk.
 - ♦ Making meth creates solid waste as well.
 - ♦ For every pound of meth produced, 5 to 6 pounds of toxic waste are created.⁸
 - ♦ This waste usually is dumped on the ground, dumped into local waterways, or flushed into sewer or septic systems, contaminating the surrounding area.
- Handout FE 4A summarizes these meth facts.

Slide 4-29—Cocaine

- The next stimulant to be discussed is cocaine, a drug that is made from the leaves of the coca plant.

Slide 4-30—Street Names

- Powdered cocaine (cocaine hydrochloride, a salt) is known on the street as
 - ♦ Coke
 - ♦ Flake
 - ♦ Snow
 - ♦ Blow

Slide 4-31—Crack Cocaine

- Crack cocaine is cocaine that has been processed from cocaine hydrochloride into a rock crystal form that can be smoked.
- It gets its name from the cracking sound it makes when heated.
- Crack is sometimes called “rock” or “freebase.”
- When people process cocaine hydrochloride themselves and smoke the result, it often is called “free basing.”

Slide 4-32—Popularity of Cocaine⁹

- The 2004 NSDUH survey estimated that nearly 34 million Americans have used cocaine at some time in their lives.
- The same survey estimated the following:
 - ♦ About 2 million people in the United States currently use cocaine.
 - ♦ Some 2.5 percent of young people ages 12 to 17 reported that they had used cocaine at least one time. Nearly 9 percent of 18 year olds reported using cocaine at least once.
 - ♦ Among young adults ages 18 to 25, 16 percent reported using cocaine at least one time.

Slide 4-33—Who Uses Cocaine?¹⁰

- Adults 18 to 25 years old have a higher rate of current cocaine use than those in any other age group.
- Overall, men have a higher rate of current cocaine use than do women.

Slide 4-34—Immediate Psychological Effects

- The immediate *psychological* effects of cocaine are similar to those of meth and include
 - ♦ Euphoria
 - ♦ Increased energy
 - ♦ Increased talkativeness
 - ♦ Increased sensitivity to sensations of sight, sound, and touch
 - ♦ Increased mental alertness
 - ♦ Increased confidence
 - ♦ Intensified feelings of sexual desire

Slide 4-35—Immediate Physical Effects

- The immediate *physical* effects of cocaine include
 - ♦ Constricted blood vessels
 - ♦ Dilated pupils
 - ♦ Increased heart rate
 - ♦ Increased temperature
 - ♦ Increased blood pressure
 - ♦ Decreased appetite
 - ♦ Decreased sleep

Slide 4-36—Warning

- In rare instances, sudden death can occur with cocaine use, even the first time someone uses the drug.
- Drinking alcohol with cocaine increases this risk.
- The liver combines cocaine and alcohol and manufactures a third substance, cocaethylene.
- Cocaethylene intensifies cocaine's euphoric effects, while increasing the risk of sudden death.

Slide 4-37—Chronic Psychological Effects

- Chronic *psychological* effects of cocaine use include
 - ♦ Irritability
 - ♦ Depression
 - ♦ Increasing restlessness
 - ♦ Paranoia
 - ♦ Auditory hallucinations
 - ♦ Possible bizarre and/or violent behavior (with high doses)
 - ♦ Damaged ability to feel pleasure without the drug
 - ♦ Exposure to HIV or hepatitis C virus through reckless, unprotected sex

Slide 4-38—Chronic Physical Effects

- Chronic *physical* effects of cocaine use include
 - ♦ Cardiovascular effects, such as
 - Disturbances in heart rhythm
 - Heart attacks
 - ♦ Respiratory effects, such as
 - Chest pain
 - Respiratory failure
 - Bronchitis and pneumonia

- ♦ Neurological effects, such as
 - Strokes
 - Seizures
 - Loss of appetite over time leading to significant weight loss and malnutrition
 - Headaches

Slide 4-39—Injecting Cocaine

- Like meth, the way in which cocaine is used may cause particular problems. People who regularly *inject* cocaine may experience
 - ♦ Abscesses (infected sores) at injection sites
 - ♦ Allergic reactions, either to the drug or to some additive in street cocaine, which can result in death
 - ♦ Exposure to HIV and hepatitis C virus

Slide 4-40—Snorting Cocaine

- Regularly *snorting* cocaine can lead to
 - ♦ Loss of sense of smell
 - ♦ Problems with swallowing
 - ♦ Overall irritation of the nasal septum leading to a chronically inflamed, runny nose
 - ♦ Nosebleeds
 - ♦ Hoarseness
 - ♦ Deviated septum

Slide 4-41—Smoking Crack

- *Smoking* crack cocaine can lead to
 - ♦ Throat problems
 - ♦ Burned lips
 - ♦ Lung congestion
 - ♦ Severe coughing
 - ♦ Chronic lung disease

Slide 4-42—Cocaine Dose and Effects

- As with people who use meth, people who use cocaine regularly develop tolerance for the effects of the drug and use higher and higher doses to get the same euphoric effect.
- Higher doses and more frequent use increase the likelihood of toxic effects.

Slide 4-43—Pregnancy and Cocaine

- Using cocaine during pregnancy may cause serious problems for a woman's fetus.

- The drug passes through the placenta, enters the fetus' bloodstream, and passes through the fetal brain barrier.
- Babies born to mothers who used cocaine during pregnancy may¹¹
 - ◆ Be born prematurely
 - ◆ Have smaller than normal heads
 - ◆ Have low birth weights
 - ◆ Be shorter than normal
- Babies also may be exposed to HIV or hepatitis virus if the mother is infected.

Slide 4-44—Cocaine-Exposed Children

- Fetal cocaine exposure does not seem to cause as serious and long-lasting problems as was once thought.
- However, as cocaine-exposed children grow up, they may have subtle, yet significant, problems later in life in areas that are important for success in school, such as¹²
 - ◆ Paying attention to tasks
 - ◆ Learning new information
 - ◆ Thinking things through
- Handout FE 4B summarizes these cocaine facts.

1 Substance Abuse and Mental Health Services Administration (SAMHSA). *The NSDUH Report: Methamphetamine Use, Abuse, and Dependence: 2002, 2003, and 2004*. Rockville, MD: Office of Applied Studies, SAMHSA, September 16, 2005. www.oas.samhsa.gov/2k5/meth/meth.pdf [accessed March 2, 2006].

2 National Institute on Drug Abuse. *NIDA Community Drug Alert Bulletin: Methamphetamine*. Bethesda, MD: National Institutes of Health, 1998. www.drugabuse.gov/MethAlert/MethAlert.html [accessed September 16, 2005].

3 Office of National Drug Control. *Fact Sheet: Methamphetamine*. Rockville, MD: Drug Policy Information Clearinghouse, November 2003. www.whitehousedrugpolicy.gov/publications/pdf/ncj197534.pdf [accessed September 16, 2005].

4 See note 1.

5 See note 2.

6 See note 3.

7 See note 3.

8 See note 3.

9 Substance Abuse and Mental Health Services Administration (SAMHSA). *Results From the 2004 National Survey on Drug Use and Health: National Findings*. NSDUH Series H-28, DHHS Publication No. (SMA) 05-4062. Rockville, MD: Office of Applied Studies, SAMHSA, 2005.

10 National Institute on Drug Abuse. *Research Report Series: Cocaine Abuse and Addiction*. NIH Publication No. 99-4342. Bethesda, MD: National Institutes of Health, revised November 2004. www.nida.nih.gov/PDF/RRCocain.pdf [accessed September 16, 2005].

11 See note 9.

12 See note 10.

Session 5: Roadmap for Recovery (PowerPoint Presentation)

Overview

Goals of Session

- Help participants understand what to expect as clients recover by describing a four-stage model of recovery.
- Help participants recognize the characteristics of each stage of recovery.
- Help participants recognize particular relapse risks clients may face in each stage of recovery.
- Help participants learn more about triggers for drug craving and ways both clients and their family members can avoid or cope with these triggers.

Handouts

- FE 5A—Daily/Hourly Schedule
- FE 5B—Relapse Justifications

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 44 through 55 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from www.kap.samhsa.gov by clicking on Products, clicking on Resource Documents & Manuals, and then clicking on the Matrix icon.

Slide 5-1—Roadmap for Recovery

- This presentation will look at recovery as following a predictable course (like a roadmap) through a series of four recovery stages.
- People in recovery are likely to experience particular physical and emotional changes and symptoms in each stage of recovery, and each stage brings particular relapse risks. Families are likely to witness these changes and symptoms.
- This does not mean that every person or family will experience recovery in exactly the same way; although the general progression is predictable, every person in recovery will follow his or her own roadmap.
- A few people will progress from stage to stage smoothly, many will become “stuck” for a time in one stage, and others will veer off track completely before resuming their progress.
- Even though there will be variability, being aware of the stages of recovery can give people in recovery and their family members a basic idea of what to expect during recovery.
- Knowing what to expect can help people avoid pitfalls and stay on the road to recovery.
- Knowing what to expect also helps family members understand the recovery process and allows them to provide more support for the person in recovery.

Slide 5-2—Recovery Stages

- Recovery stages we will discuss include
 - ◆ Stage 1: Withdrawal
 - ◆ Stage 2: Early abstinence (sometimes called the “Honeymoon” or “pink cloud” stage)
 - ◆ Stage 3: Protracted abstinence (sometimes called “the Wall”)
 - ◆ Stage 4: Adjustment and resolution

Slide 5-3—Stage 1: Withdrawal

- The withdrawal stage begins when a person first stops using drugs and alcohol.
- This stage lasts from 1 to 2 weeks.
- Typical characteristics of the withdrawal stage (particularly for those who used methamphetamine or other stimulants) include
 - ◆ Physical detoxification
 - ◆ Intense cravings for the drug
 - ◆ Depression or anxiety
 - ◆ Low energy
 - ◆ Irritability or aggression
 - ◆ Exhaustion
 - ◆ Insomnia *and* extended periods of sleep
 - ◆ Disordered thinking
 - ◆ Paranoia
 - ◆ Memory problems and difficulty concentrating
 - ◆ Intense hunger

- If people have been using other drugs heavily, such as tranquilizers, barbiturates, or heroin, or have been drinking alcohol heavily, they may experience symptoms of physical withdrawal from those substances, as well.
- The depression, anxiety, and paranoia people experience when first abstaining from stimulants are the direct result of the brain's adjusting to the absence of a stimulant drug and, in most cases, are temporary.
- It is important for both people in this stage of recovery and their family members to understand that these emotions will pass, but such emotions can lead to suicidal thoughts or plans in the short term. If the depression, anxiety, or paranoia persists or is very severe, a psychiatric consultation may be recommended.
- In addition to experiencing the characteristics/symptoms listed, people in recovery may need medical attention for problems resulting from their drug use, such as
 - ♦ Seizures
 - ♦ Infections at injection or skin popping sites
 - ♦ Cardiovascular problems
 - ♦ Severe weight loss
 - ♦ Vitamin deficiencies
 - ♦ Respiratory problems
 - ♦ HIV/AIDS
 - ♦ Hepatitis C

Slide 5-4—Withdrawal (Relapse Risk Factors)

- During the withdrawal stage, people tend to feel out of control of their lives.
- Symptoms such as paranoia, depression, fear of withdrawal, and disordered sleep patterns contribute to vulnerability to cravings.
- Unstructured time and proximity to triggers increase the risk of relapse.

Slide 5-5—Withdrawal (Structure)

- The concept of *structure* is an important part of Matrix treatment.
- People in outpatient treatment, with the help of their family members, must learn to design their own structure because outpatient treatment does not provide the structure of an inpatient facility.
- Creating structure by scheduling their time can help people in recovery feel more in control of life.
- Self-designed structure
 - ♦ Helps eliminate avoidable triggers by providing a *plan* to avoid them
 - ♦ Makes the concept of “one day at a time” concrete
 - ♦ Reduces anxiety
 - ♦ Counters the drug-using lifestyle
 - ♦ Provides a basic foundation for ongoing recovery
- Matrix clients learn to schedule their time outside treatment.
- Family members can help by supporting clients' scheduling efforts.

Slide 5-6—Building Blocks of Structure

- With the help of their counselor and family members, people in recovery create structure by organizing and planning their time using schedule sheets.
- Handout FE 5A—Daily/Hourly Schedule provides an example of a form that can be used to help clients structure their time.
- The building blocks of a person's structure should incorporate new drug-free behavioral options, such as
 - ◆ Treatment activities
 - ◆ Interest in new or long-dormant recreational/leisure activities
 - ◆ Attending 12-Step or mutual-help group meetings
 - ◆ Work, school, or volunteer activities
 - ◆ Physical exercise and sports
 - ◆ Activities with friends who are drug free
 - ◆ Time scheduling
 - ◆ Family-related events
 - ◆ Spiritual activities
 - ◆ “Island building” (planning specific events or “islands” of rest, relaxation, or fun to look forward to)
- The end result is a daily plan for activities that promotes recovery and reduces the possibility of boredom, impulsive decisionmaking, exposure to triggers, and relapse.

Slide 5-7—Scheduling Pitfalls

- Scheduling should be a positive experience, but sometimes scheduling can become tedious or stressful.
- Some scheduling problems that a person in recovery can encounter include
 - ◆ Unrealistic schedules (for example, working 8 hours, taking children to an afterschool activity, attending a Matrix group session, attending a 12-Step meeting, and exercising—all in 1 day)
 - ◆ Unbalanced schedules (not enough or too much leisure time, for example)
 - ◆ Imposed schedules (allowing others to tell one what to do and when to do it, for example, rather than choosing activities oneself)
 - ◆ No support from significant others
 - ◆ Holidays, illness, and other changes that can disrupt one's schedule
- It is important that clients in Matrix treatment work closely with their counselor to learn how to schedule appropriately and to plan for coping with unusual events that disrupt the schedule.
- It is equally important that family members support clients' efforts to schedule their time.
- Scheduling and creating structure in one's life is a skill that needs to be practiced.

Slide 5-8—Stage 2: Early Abstinence

- The early abstinence stage is sometimes called the Honeymoon or pink cloud stage because it is the stage in which people often feel much better and start to think that their problems with substances are solved.
- This stage usually lasts for about 4 weeks.
- Typical characteristics of the early abstinence stage (particularly for those who used methamphetamine or other stimulants) include
 - ♦ Increased energy and optimism
 - ♦ Overconfidence
 - ♦ Difficulty concentrating
 - ♦ Continued memory problems
 - ♦ Concerns about weight gain
 - ♦ Intense feelings
 - ♦ Mood swings
 - ♦ Other substance use
 - ♦ Inability to prioritize
 - ♦ Mild, continuing paranoia

Slide 5-9—Early Abstinence (Relapse Risk Factors)

- During this stage, people's moods typically improve, they have more energy, cravings diminish, and confidence and optimism increase.
- This increased energy leads some people to become overinvolved with their work; "workaholism," in turn, may lead to relapse as recovering people
 - ♦ Neglect self-care
 - ♦ Decrease their involvement in treatment and other recovery activities
 - ♦ Become overtired and stressed
- Overconfidence also may cause problems; people in recovery may start to believe "I've got this substance problem licked." This belief can lead them to think that they
 - ♦ No longer need treatment
 - ♦ Can safely be around friends and family members who still are using drugs or go to places where they used drugs
 - ♦ Can safely use a drug other than their "problem" drug or drink alcohol
- Exposure to triggers and using secondary drugs or alcohol often may lead to relapse to methamphetamine or other stimulant use.
- People in this stage also may experience
 - ♦ Concerns over weight gain
 - ♦ An inability to prioritize
 - ♦ Resistance to continued behavior change
 - ♦ Occasional paranoia

- ♦ Anxiety about changes in sexual behavior

■ People in recovery in this stage need to

- ♦ Recognize the risks in this stage of recovery
- ♦ Learn to channel Honeymoon energy toward specific recovery tasks, putting together a solid structure of activities to build momentum that will carry them through subsequent recovery stages

■ Family members, too, need to recognize that, although people in recovery appear to be better and more optimistic, they still need support and encouragement to

- ♦ Attend all treatment activities
- ♦ Abstain from all drugs and alcohol
- ♦ Attend 12-Step or mutual-help group meetings
- ♦ Continue careful scheduling of their time
- ♦ Avoid people and places associated with drug use
- ♦ Participate in regular physical exercise

Slide 5-10—Early Abstinence (Triggers and Thought Stopping)

- No matter how carefully people in recovery schedule their time, it is likely that they will encounter a person, place, situation, or emotional state that triggers thoughts about using.
- People in the early abstinence stage of recovery need to understand the concepts of triggers and thought stopping. Family members also need to understand this concept.
- To people in recovery, the trigger–thought–craving–use sequence can feel as if all parts of the sequence happen simultaneously.
- In fact, recovering people can learn to interrupt the sequence at any point.

Slide 5-11—Interruption

- Another way to envision this process is to see the trigger–thought–craving–use sequence as moving down a steep slide.
- The time to use thought stopping is right after one recognizes the first thought of using.
- At that point, the urge to use, as shown by the small circle moving toward the figure, is still relatively small and containable.
- It still is possible to stop this process when it reaches the craving stage, but then it is much more difficult. When a person is in the craving mode, the small circle has become enormous—a huge force that is nearly out of control.
- The person in recovery may not want to use and may attempt to deflect the cravings, but more often than not, the cravings are so powerful that they propel the person into relapse.
- A first step toward learning to interrupt the trigger–thought–craving–use sequence is to understand what constitutes a trigger and to learn to recognize a trigger as quickly as possible.

Slide 5-12—Types of Triggers

■ Triggers can relate to

- ♦ People
- ♦ Places
- ♦ Things
- ♦ Times
- ♦ Emotional states

Slide 5-13—Triggers (People)

■ Triggers related to *people* may include

- ♦ Friends who use drugs
- ♦ Absence of a significant other (loneliness)
- ♦ Voices of friends who use drugs/dealers (for example, on phone calls)
- ♦ Drug dealers
- ♦ Partners in meth-related sexual activity
- ♦ People discussing drug use in a positive way

Slide 5-14—Triggers (Places)

■ Triggers related to *places* may include

- ♦ Drug dealer's home
- ♦ Bars and clubs
- ♦ Drug use neighborhoods
- ♦ Work
- ♦ Some street corners
- ♦ *Anyplace* associated with use

Slide 5-15—Triggers (Things)

■ Triggers related to objects or *things* may include

- ♦ Drug paraphernalia
- ♦ Money/ATMs
- ♦ Movies and TV shows about or depicting drug and alcohol use
- ♦ Sexually explicit magazines and movies
- ♦ Certain music associated with using
- ♦ Using a drug other than the identified problem drug or drinking alcohol

Slide 5-16—Triggers (Times)

■ Triggers related to particular *times* include

- ♦ Idle time
- ♦ After work
- ♦ Holidays
- ♦ Birthdays, anniversaries, and other special occasions
- ♦ Stressful times
- ♦ Paydays
- ♦ Friday and Saturday nights

Slide 5-17—Triggers (Emotional States)

- The reality for most recovering people is that *any* emotional state, positive or negative, can be a trigger if it has been associated with drug or alcohol use.
- Triggers related to emotional states include
 - ♦ Anxiety
 - ♦ Depression
 - ♦ Boredom
 - ♦ Fear
 - ♦ Sexual arousal, deprivation, or anxiety about performance
 - ♦ Fatigue (or fear of becoming fatigued)
 - ♦ Anger
 - ♦ Frustration
 - ♦ Concern about weight gain

Slide 5-18—Thought Stopping

- Thought-stopping techniques can be used to interrupt the trigger–thought–craving–use cycle.
- The first step in successfully using thought-stopping techniques is to recognize thoughts about using (“using thoughts”) as soon as they occur.
- People new to recovery don’t always realize when they are having using thoughts, but they can learn to do so by consciously focusing on their thought processes.
- Once people recognize a using thought, they can choose to interrupt the thought by using one of these thought-stopping techniques:
 - ♦ Visualization
 - When people experience thoughts of using drugs or alcohol, they can visualize a switch or lever and imagine actually moving it from ON to OFF to stop the drug- or alcohol-using thoughts.
 - It is important to have another thought ready to replace the drug- or alcohol-using thoughts.
 - The thought should be a pleasurable one or one that is meaningful to the person and does not involve drug or alcohol use.
 - ♦ Rubberband snap
 - The rubberband technique helps recovering people “snap” their attention away from thoughts of using drugs or alcohol.
 - People simply can put a rubberband loosely around their wrist.
 - When a craving or using thought occurs, people snap the rubberband lightly against their wrist and say “NO” (either aloud or not, depending on the situation) to the drug or alcohol thoughts.

- As with visualization, people need to have another thought ready to replace the drug- and alcohol-using thoughts.
- This technique works best if people leave the rubberband on all the time.

♦ Relaxation

- Cravings often create feelings of hollowness, heaviness, and cramping in the stomach.
- These feelings often can be relieved by breathing in deeply (filling the lungs with air) and slowly breathing out, repeating the process three times, and focusing on relaxing the body as much as possible for a few minutes.
- This process can be repeated as often as the feelings return.

♦ Calling someone

- Talking to others provides an outlet for feelings and allows people to “hear” their thought process.
- People in recovery should carry the phone numbers of supportive people, including family members, with them so they can call someone whenever support is needed.

Slide 5-19—Nontrigger Activities

- If thought stopping works, but the thoughts frequently keep coming back, people in recovery may have to change their immediate environments or engage in tasks that require full concentration.
- A few examples of nontrigger activities include
 - ♦ Exercise
 - ♦ 12-Step/mutual-help group meetings
 - ♦ New recreational activity or hobby
 - ♦ Activities in the person’s faith-based or spiritual community
 - ♦ Meditation or prayer
 - ♦ Eating or sleeping
 - ♦ Non–drug-oriented movies
 - ♦ Structured/monitored periods (time with family or friends who do not use, for example)
- A person in recovery should keep a list of such activities handy for times when they may be needed.

Slide 5-20—Stage 3: Protracted Abstinence

- The protracted abstinence stage typically lasts for about 3 to 4 months.
- This stage (sometimes called the Wall) brings a shift back from the high of the Honeymoon phase to a period of low energy and an emotional state often characterized by apathy, depression, and anhedonia (inability to experience pleasure).

- This shift is likely even though people in recovery are continuing to make positive changes in their lives and are beginning to reap the benefits of recovery.
- Common characteristics of this stage of recovery include
 - ♦ Continued lifestyle changes
 - ♦ Anger and depression
 - ♦ Episodes of paranoia or suspicion
 - ♦ Isolation
 - ♦ Family adjustment and conflict
 - ♦ Concerns about loss of sex drive, difficulties with sexual performance, and reduction in sexual activity
 - ♦ Positive benefits from abstinence
 - ♦ Emotional swings
 - ♦ Unclear thinking
 - ♦ Weight gain
 - ♦ Return of cravings
 - ♦ Return to old behaviors
- It is important for people in recovery and their family members to know that the changes of this stage are the result of a continuing healing process in the brain and that, if people remain abstinent, their brain chemistry will stabilize and the negative emotions and the low energy of this stage will pass.

Slide 5-21—Protracted Abstinence (Relapse Risk Factors)

- Relapse factors common to this stage include
 - ♦ Increased emotionality
 - ♦ Behavioral “drift”
 - ♦ Decreased ability to feel pleasure
 - ♦ Concern about weight gain
 - ♦ Poor self-care
 - ♦ Low energy/fatigue
 - ♦ Secondary drug or alcohol use
 - ♦ Breakdown of structure
 - ♦ Interpersonal conflict
 - ♦ Loss of motivation
 - ♦ Sexual anxieties
 - ♦ Insomnia
 - ♦ Paranoia
 - ♦ Relapse justification
- The person in recovery is particularly vulnerable to relapse during the protracted abstinence stage because the person often perceives that the negative emotional states and low energy common to this stage will persist indefinitely.
- The person in this stage of recovery may begin to think that if recovery feels this bad, it may not be worth it.
- This thinking, and the low energy and fatigue, can lead to behavioral drift, a gradual letting go of the structure (including treatment activities and 12-Step or mutual-help group meetings) and other behavioral changes the person has worked hard to achieve.

- As structure breaks down, the person may experience more thoughts about using drugs or alcohol and begin to create justifications for use.
- It is critical that the person in recovery anticipate the Wall and understand it is a temporary phase.
- It is critical that a person in recovery remain in treatment and continue the behavioral changes already made to this point to avoid a sequence of inertia, boredom, loss of recovery focus, relapse justification, and, finally, relapse.
- Good self-care, particularly regular exercise, and the understanding and support of family members can greatly help a person negotiate this phase successfully.

Slide 5-22—Secondary Drugs and Alcohol

- It is quite common for people in all stages of recovery to entertain at times the idea of using drugs other than those they consider to be their primary problem drug (called “secondary drugs”) or alcohol.
- The use of secondary drugs is a particular relapse risk in the protracted abstinence stage of recovery because of the uncomfortable emotional states common to the stage and the tendency for decreasing supportive structure.
- People in recovery may begin to tell themselves, “My problem is with methamphetamine; I’ve never had a problem with pot. I just need to relax a little.”
- Using a secondary drug or alcohol is a bad idea and may lead quickly to relapse to using one’s primary drug in a number of ways:
 - ♦ **Cortical disinhibition.** Using a secondary drug or alcohol can cause the prefrontal cortex, the part of the human brain responsible for rational decisionmaking, to become disinhibited (less active), thus paving the way for a return to the primary drug use. This effort is especially likely if secondary drug use exposes people to triggers associated with their use of the primary drug (buying from a dealer, for example).
 - ♦ **Stimulant craving induction.** Studies at the Matrix Institute have shown that, if cocaine or amphetamines are the drugs of choice, a return to alcohol use will increase the risk of relapse to stimulants by 800 percent. A return to the use of marijuana will do the same by 300 percent. This result remains true even if the client was not addicted to alcohol or marijuana.
 - ♦ **12-Step group philosophy conflict.** If people in recovery use a secondary drug or alcohol, they are unlikely to continue to attend 12-Step groups, groups that are vital to recovery, because using any illicit drug or alcohol is contrary to 12-Step group philosophy and people will be increasingly uncomfortable in meetings.
 - ♦ **Abstinence violation effect.** There is a strong tendency for people to begin thinking, “Well, I’m drinking again; I might as well use a little meth, too.”
 - ♦ **Interference with new behaviors.** Using a secondary drug or alcohol to cope with problems or life stresses will interfere with learning new coping behaviors, which are necessary to ensure long-term recovery.

Slide 5-23—Protracted Abstinence (Relapse Justification)

- Relapse justification occurs when the addicted brain attempts to provide a *seemingly* rational reason (justification) for behavior that moves a person in recovery closer to a slip.
- It is critical that people in recovery and their family members learn to recognize a relapse justification as soon as it arises.
- Most relapse justifications are based on the faulty premise that people in recovery have no choice about whether to use drugs or remain in recovery.
- Although at some point, using does become inevitable (for example, once people are at their dealer's house, they probably no longer have a choice; the craving is then in control), they *can* choose not to put themselves in risky situations.
- Relapse thoughts gain power when they are not recognized or discussed openly.
- Relapse justifications can take many forms:
 - ◆ Other people made me do it.
 - ◆ I needed it for a specific purpose.
 - ◆ I was testing myself.
 - ◆ It wasn't my fault.
 - ◆ It was an accident.
 - ◆ I felt bad.

Slides 5-24 through 5-29—Relapse Justifications

- Handout FE 5B—Relapse Justifications identifies the excuses for using on slides 5-24 through 5-29 and discusses the process of relapse justification.

Slide 5-30—Stage 4: Adjustment and Resolution

- The adjustment/resolution stage typically lasts for about 4 to 6 months.
- Although a person is well past physical withdrawal and may have mended from many or most of the physical effects of substance use, recovery is far from complete.
- There often is a great feeling of accomplishment at having passed the Wall stage.
- This feeling can result in a false sense that, finally, one's life can return to pretreatment normalcy.
- People in recovery who successfully cope with this stage (and their family members) must recognize that the lifestyle and relationship changes made are now the new definition of "normal."
- Once people have completed treatment, they need to shift from learning new skills to
 - ◆ Maintaining a balanced lifestyle
 - ◆ Recognizing and accepting that recovering from addiction is a life-long process
 - ◆ Monitoring for relapse signs
 - ◆ Developing new areas of interest
- Because of increasing emotional stability in this stage, the person may be ready to address significant, and sometimes volatile, underlying issues that were avoided or had not emerged before.

Slide 5-31—Adjustment and Resolution (Relapse Risk Factors)

- Because cravings occur less often and feel less intense by this stage of recovery, people may
 - ♦ Believe that they now can use a secondary drug safely
 - ♦ Relax their vigilance for relapse signs
 - ♦ Relax the recovery structure they have created, putting themselves in high-risk situations
 - ♦ Return to relationships with people who use stimulants
 - ♦ Neglect recovery activities, losing the momentum of recovery
 - ♦ Neglect exercise and other self-care activities
- People in recovery and their families also may struggle with acceptance of the addiction and the life-long nature of recovery.
- Emerging or reemerging emotional or relationship issues may cause distress and a desire to use drugs or alcohol; these issues need to be addressed in a counseling or treatment setting to avoid possible relapse.

Slide 5-32—Adjustment and Resolution (Balance)

- A critical task for this stage of recovery (and in the future) is developing balance in one's life.
- This representation of a recovery pie illustrates the lifestyle balance necessary to sustain ongoing abstinence and sobriety.
- Every individual needs to find the optimal balance that works.
- Families can help people in recovery find and maintain this balance in their lives.

Session 6: Coping With the Possibility of a Relapse (Multifamily Group Discussion)

Goals of Session

- Help participants explore their feelings and fears about relapse.
- Help clients and their family members better understand one another's fears and needs.
- Help participants share ideas for coping with relapse.

Handouts

- FE 6A—Coping With the Possibility of Relapse: For the Person in Recovery
- FE 6B—Coping With the Possibility of Relapse: For Family Members of the Person in Recovery
- FE 6C—Family Members and Recovery

Introduction (2–3 minutes)

The counselor explains that

- Today's session provides an opportunity for clients and their family members to discuss issues and fears related to the possibility of relapse.
- Relapse to drug or alcohol use can occur only after abstinence is achieved.
- Many people experience relapse at some point. Recovery is like learning any difficult skills; most people are not able to acquire the skills of recovery without making mistakes.
- However, relapse is not inevitable. Some people achieve long-term recovery without relapsing.
- Family members can relapse, too; those who have learned new, healthier ways of communicating and behaving can relapse to old behavior and ways of communicating and can stop taking care of themselves when the family member in recovery relapses to drug or alcohol use.
- It is normal for people in recovery and their family members to fear relapse.

Handout Review (10–15 minutes)

The counselor

- Gives clients a copy of handout FE 6A—Coping With the Possibility of Relapse: For the Person in Recovery and asks them to read the information and carefully consider and write down their answers to the questions
- Gives family members a copy of handout FE 6B—Coping With the Possibility of Relapse: For Family Members of the Person in Recovery and asks them to read the information and carefully consider and write down their answers to the questions

- Tells participants that their answers to the questions are to guide discussion; no one will see their responses

Focused Discussion (50–55 minutes)

The counselor

- Facilitates discussion, using the questions on the handouts to provide structure
- Reinforces good ideas for coping with relapse that are brought up in the discussion

Summary (2–3 minutes)

The counselor

- Summarizes the ideas for effectively coping with relapse that were discussed by the group
- Gives family members handout FE 6C—Family Members and Recovery
- Explains that the handout contains some concepts that are important for family members of a person in recovery to remember and that referring to it from time to time may be helpful

Open Discussion (15 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Session 7: Opioids and Club Drugs (PowerPoint Presentation)

Overview

Goals of Session

- Familiarize participants with the nature and prevalence of two groups of drugs: opioids (e.g., heroin, oxycodone, and morphine) and club drugs (e.g., ketamine, LSD, and ecstasy).
- Familiarize participants with the dangers to health and to recovery posed by opioids and club drugs.

Handouts

- FE 7A—Fact Sheet: Opioids
- FE 7B—Fact Sheet: Club Drugs

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 58 through 66 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from www.kap.samhsa.gov by clicking on Products, clicking on Resource Documents & Manuals, and then clicking on the Matrix icon.

Slide 7-1—Opioids and Club Drugs

- This presentation offers an overview of opioids and club drugs, including what they are, who uses them, their effects on the body, and the risks they pose to recovery.
- Handouts FE 7A—Fact Sheet: Opioids and FE 7B—Fact Sheet: Club Drugs summarize the information that is discussed during this session.

Slide 7-2—The Importance of Total Abstinence

- For treatment to work, people in recovery should be totally abstinent. Abstaining from *all* psychoactive substances greatly increases the chances of a successful recovery.
- If people are in treatment for abusing stimulants, they must give up alcohol and *all* illegal drugs, including drugs such as marijuana that some people believe are harmless, to ensure a successful recovery.

Slide 7-3—What Are Opioids?

- Opioids are a group of drugs that act on the opiate receptors in the brain. Opioids can be made from natural sources (e.g., poppy plants) or synthetically.
- Natural opioids (like morphine and heroin) and synthetic opioids (like meperidine and oxycodone) have similar effects.
- Opioids treat pain effectively because they dull sensation and relieve the anxiety that comes from anticipating pain.
- People abuse opioids because they provide a powerful feeling of euphoria or a “rush.”

Slide 7-4—Physical Effects of Opioids

- Once opioids enter the brain, they take effect in a matter of minutes.
- The physical signs of opioid use are constricted pupils, flushing of the skin, and a heavy feeling in the limbs. People on heroin are described as “nodding” because they look as if they are about to fall asleep.
- The rush of euphoria is followed by a drowsy state. Breathing and heart rate slow during this time. Headaches and dizziness are common. These immediate effects fade a few hours after the drug is taken.

Slide 7-5—Opioids and Tolerance

- As people continue to use opioids, higher and higher doses are required to achieve the same effect. This is called “tolerance.”
- Eventually, a person’s tolerance for opioids means that the drug is taken mainly to stave off withdrawal, not to get high.

Slide 7-6—Dependence Versus Addiction

- Repeated use of opioids can result in dependence and addiction.
- People who take opioids that have been prescribed by their doctors to treat pain rarely become addicted.
- With long-term use, even people who take medication as prescribed can become dependent on opioids.
- These people must stop taking opioid pain medication gradually or they will have withdrawal symptoms.

- Addiction is marked by physical dependence accompanied by a compulsive urge to take the drug, even if negative consequences result.

Slide 7-7—Withdrawal From Opioids

- A person who is dependent or addicted will go through withdrawal if opioids are discontinued suddenly. Symptoms of withdrawal include restlessness, severe muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes, and goose bumps (the origin of the phrase “going cold turkey,” used to describe going into withdrawal).
- Withdrawal can take up to a week to run its course. It is rarely fatal to healthy adults, but it can result in early labor or miscarriage in a woman who is pregnant.

Slide 7-8—Abuse of Prescription Opioids

- The main prescription opioids that people abuse are codeine, oxycodone (OxyContin®, Percodan®, Percocet®, Tylox®), hydrocodone (Vicodin®), meperidine (Demerol®), and hydromorphone (Dilaudid®).
- We will focus on oxycodone in the next few slides. OxyContin is the strongest form of oxycodone available.

Slide 7-9—Oxycodone (Use Patterns)

- Oxycodone abuse appears to be increasing.
- According to the 2004 National Survey on Drug Use and Health, more than 10 percent of people in the United States ages 18 to 25 have used oxycodone nonmedically. The number of people abusing oxycodone has increased every year since the drug was introduced in 1995.¹
- Most of the people who abuse oxycodone are older than 30.²
- In 2004, 5 percent of high school seniors reported using oxycodone at least once.³

Slide 7-10—Oxycodone (Facts)

- Oxycodone is a timed-release tablet that is prescribed for people with long-lasting pain, such as pain from cancer or back pain.
- People obtain oxycodone illegally by pretending to be in pain, forging prescriptions, and robbing pharmacies.
- To defeat the timed-release action, people who abuse oxycodone crush the tablet and then swallow or snort it or dissolve it in water and inject it.
- When taken in these ways, oxycodone produces a euphoric high like that of heroin.
- Oxycodone's street names include oxy, OC, kickers, killers, blue, and hillbilly heroin.

Slide 7-11—Oxycodone (Dangers)

- OxyContin contains a much larger dose of opioid than do other oxycodone formulations, such as Percodan or Percocet.

- When tablets are crushed before they are taken, the risks of dangerously slow breathing, heart attack, and overdose increase.
- People who dissolve the tablets and inject the solution face diseases such as hepatitis and HIV/AIDS that are linked with dirty needles.
- Like all opioids, oxycodone is highly addictive when abused.

Slide 7-12—Heroin (Use Patterns)

- The main natural opioids that people abuse are heroin and morphine. We will focus on heroin in the next few slides.
- Some 1.6 percent of people 12 years and older have used heroin. More than 3.1 percent of high school students have used heroin.⁴
- As many as 1 million people in the United States may be addicted to heroin.⁵
- Among Caucasians, Hispanics, and all people younger than 26, heroin is linked to more deaths than any other substance except alcohol.⁶
- Heroin is connected with 15 percent of all visits to emergency rooms in the United States.⁷
- Most people who use heroin are Caucasian males older than 30 who live in urban areas.⁸ The age at which people start using heroin had dropped from the middle twenties in 1990 to the early twenties in 2000.⁹
- Increasing use among younger people is partly attributable to the purer forms of heroin that have become cheaper and more widely available in recent years. This purer heroin can be smoked or snorted, rather than injected.
- Smoking or snorting heroin has increased in popularity because people mistakenly assume that smoking or snorting heroin will not lead to addiction. Fear of using needles also has contributed to increasing use of these routes of administration.

Slide 7-13—Heroin (Facts)

- Heroin is made from morphine, which is derived from poppy plants. It was used widely as a pain remedy in the late 19th and early 20th centuries. Because it is highly addictive and other painkillers were available, heroin was banned in 1914.
- Pure heroin is a white powder. Heroin purchased on the street varies in color from white to dark brown and usually is mixed with other substances such as sugar, powdered milk, starch, or poisons such as strychnine.
- Heroin is known by many street names, including smack, horse, big H, junk, dope, skag, and poison.

Slide 7-14—Heroin (Dangers)

- People who use heroin often become so focused on obtaining the drug that they neglect most other aspects of their lives.

- Some experience weight loss, dehydration, and malnutrition. Some become impoverished and turn to crime.
- Because the purity of heroin varies, accidental overdose is a prominent danger.

Slide 7-15—Heroin (Disease Risks)

- Most people who use heroin regularly inject it. Those who start out smoking or snorting heroin often progress to injection because it provides a quicker and more intense rush.
- Injection drug use is estimated to be a factor in one-third of all HIV cases and more than one-half of all hepatitis C cases in the United States.
- Injecting heroin can lead to collapsed veins, clogged blood vessels, bacterial infections of the heart and blood vessels, pneumonia, tuberculosis, and liver or kidney disease.

Slide 7-16—What Are Club Drugs?

- Club drugs include a wide variety of substances, many of which are mistakenly thought to be relatively safe. They include gamma hydroxybutyrate (GHB), Rohypnol, ketamine, lysergic acid diethylamide (LSD), and MDMA or ecstasy.
- Club drugs are used primarily by people younger than 30 who are Caucasian; high school and college students show highest levels of use.
- Club drugs are used at college fraternities, dance clubs, bars, concerts, and all-night dance parties known as raves.

Slide 7-17—GHB (Use Patterns)

- Most people who use GHB are between ages 18 and 30. Most are Caucasian, middle-class males.¹⁰
- GHB use rose precipitously during the 1990s. There were 56 emergency room reports connected with GHB use in 1994; in 2002 there were nearly 5,000 such reports. That represents a 9,000-percent increase over 8 years.¹¹ Emergency room reports involving GHB have declined since 2002.¹²
- Approximately 2 percent of high school seniors used GHB at least once in 2004.¹³

Slide 7-18—GHB (Facts)

- GHB is manufactured in illegal labs from inexpensive ingredients. It is a light-colored powder that dissolves easily in liquid. When mixed with liquid, it is clear, odorless, and tasteless.
- At clubs, it often is sold in liquid form from a water or sports drink bottle, by the capful.
- GHB is known by the street names soap, easy lay, vita-G, and Georgia home boy.

Slide 7-19—GHB (Physical Effects)

- GHB produces euphoric and hallucinogenic states, accompanied by loss of control of balance, coordination, and speech. GHB takes effect 15 to 30 minutes after a dose is ingested. The effects last 3 to 6 hours.

- At high doses, dangerously slow breathing, unconsciousness, coma, and overdose can occur. If GHB is mixed with alcohol, death can result.
- Since 1990, there have been nearly 16,000 cases of GHB overdose and 70 deaths from GHB.¹⁴

Slide 7-20—Rohypnol (Use Patterns)

- Most people who use Rohypnol are 13 to 30 years old and male.¹⁵
- Rohypnol use seems to be decreasing in most parts of the country.
- Rohypnol is popular with some youth because it is cheaper than other club drugs.
- Some 1.6 percent of high school seniors used Rohypnol at least once in 2004.¹⁶

Slide 7-21—Rohypnol (Facts)

- Rohypnol is the trade name of a drug that is legal in Mexico and Europe, where it is used to treat insomnia; it has never been legal in the United States.
- Rohypnol tablets often are sold in their original packaging, which can make people think the drug is legal.
- Rohypnol is a depressant like Halcyon, Xanax, and Valium, but it is many times stronger.
- Rohypnol is known by the street names roofies, rophies, roche, rope, and the forget-me pill.

Slide 7-22—Rohypnol (Physical Effects)

- Like GHB, Rohypnol produces euphoria and hallucinations in those who take it.
- The effects of Rohypnol begin 15 to 20 minutes after it is taken and can last more than 12 hours.
- Rohypnol's effects include decreased blood pressure, slurred speech, impaired judgment, and difficulty walking.
- Rohypnol can cause headaches, nightmares, tremors, muscle pain, digestive problems, aggressive behavior, and blackouts that can last 24 hours.

Slide 7-23—Ketamine (Use Patterns)

- Ketamine is popular with students and young adults who go to nightclubs and raves.
- Ketamine use has been slowly but steadily decreasing.
- Some 1.9 percent of high school seniors used ketamine at least once in 2004.¹⁷

Slide 7-24—Ketamine (Facts)

- Ketamine is an anesthetic first used on battlefields because of its fast action. Today it is used almost exclusively by veterinarians. Veterinary clinics are robbed specifically for ketamine.
- Ketamine is produced as a liquid but usually is dried into a white, odorless, tasteless powder before it is sold illegally. It can be added to drinks, snorted, or smoked with marijuana or tobacco.
- Ketamine has no smell or taste, so it is hard to detect.

- Ketamine is known by the street names special K, vitamin K, kit kat, super acid, and jet.

Slide 7-25—Ketamine (Physical Effects)

- Ketamine produces altered perceptions and hallucinations and can induce amnesia.
- At low doses, altered perceptions include a pleasant feeling of floating or being outside one's body.
- High doses can lead to terrifying feelings of near total sensory deprivation known as the K-hole.
- The effects of ketamine begin a few minutes after it is taken and usually fade within an hour although people report not feeling fully normal again for 24 to 48 hours.
- At high doses, ketamine can cause heart attack, stroke, and oxygen starvation—all of which can lead to coma and death.

Slide 7-26—Club Drugs and Date Rape

- Along with GHB and Rohypnol, ketamine can render people confused and helpless, leaving them vulnerable to crime, especially rape.
- People who take these drugs may be unable to resist sexual acts.
- Rohypnol is tasteless and odorless and can be dissolved easily in drinks at a club.
- Newer Rohypnol tablets turn blue in a drink to increase visibility and decrease its use as a date rape drug.

Slide 7-27—LSD (Use Patterns)

- LSD is used primarily by students and young adults at clubs, raves, and concerts.
- Approximately 10 percent of people 12 and older have tried LSD; 0.2 percent used LSD at least once in 2003.¹⁸
- Use of LSD by adults has been decreasing in recent years.
- In 2004, 2.2 percent of high school seniors reported using LSD at least once in the previous year.¹⁹

Slide 7-28—LSD (Facts)

- LSD is one of the most powerful mood- and perception-altering drugs. It has no medical use.
- LSD is sometimes sold in tablet form but most often is dissolved onto blotter paper that is divided into squares. It is odorless but has a slightly bitter taste.
- LSD is known by the street names acid, blotter acid, battery acid, window pane, microdot, sunshine, and zen.

Slide 7-29—LSD (Physical Effects)

- The first effects of LSD are felt 30 to 90 minutes after it's taken. Physical changes include increased heart rate and blood pressure, sweating, nausea, dry mouth, loss of appetite, numbness, and trembling.
- At low doses, LSD produces rapid emotional swings and heightened sensations.

- At high doses, LSD induces distortions of perception: shapes change, time slows down, and sensations seem to blend. These hallucinations are called a trip.
- A bad trip can be a terrifying experience that causes confusion, panic, and fear. People experiencing LSD hallucinations have had fatal accidents.
- A trip can last up to 12 hours and often is followed by fatigue and depression.
- One of the most dangerous aspects of LSD is its unpredictability. Its effects depend on the dose, the mood of the person taking it, and the environment in which it's taken.
- People who use LSD regularly are prone to flashbacks in which they suddenly experience hallucinations without having taken the drug.
- LSD may contribute to long-term depression or schizophrenia.

Slide 7-30—MDMA (“Ecstasy”) (Use Patterns)

- The chemical MDMA, ecstasy, is used most heavily by Caucasian and upper middle-class students and young adults.²⁰
- Originally used mostly in clubs, ecstasy has spread to other social settings.
- Nearly 5 percent of people 12 and older have tried ecstasy; 1 percent used it at least once in 2003.²¹
- Some 4 percent of high school seniors used ecstasy at least once in 2004; this number appears to be decreasing.²²

Slide 7-31—Ecstasy (Facts)

- Ecstasy was used in psychotherapy in the 1970s, but it has no medical value and was banned.
- Pure ecstasy is a white powder, but it can be combined with other drugs or substances before it is sold, usually in pill form.
- Ecstasy is the drug's main street name, but it is also known as XTC, X, E, Adam, clarity, hug drug, and love drug.

Slide 7-32—Ecstasy (Physical Effects)

- The physical effects of taking ecstasy include increased heart rate and blood pressure, nausea, loss of appetite, jaw tightness, and compulsive chewing and teeth clenching.
- After getting an initial rush from taking ecstasy, people experience calm, positive feelings that last 3 to 6 hours; this process is called “rolling.”
- Ecstasy also produces increased energy, desire for visual stimulation, and heightened awareness of and response to sensory input.
- Because ecstasy increases feelings of well-being and tolerance for others, many people mistakenly consider it a harmless drug.
- Ecstasy can raise the body temperature to dangerous levels (as high as 109 degrees); these high fevers lead to dehydration, which has killed people on ecstasy.

- Because dehydration is a known risk, people who have taken ecstasy sometimes drink too much water, which can lead to a dangerous and potentially fatal condition called hyponatremia.
- Ecstasy is neurotoxic—it kills nerve cells in the brain. Studies in rats and monkeys have shown that even a few doses of ecstasy cause damage that is not repaired 7 years later.

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7 See note 5, p. 4.

8 See note 5, p. 2.

9 See note 6, p. 10.

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12 Substance Abuse and Mental Health Services Administration (SAMHSA). Club Drugs, 2002 Update. *The DAWN Report*. Rockville, MD: Office of Applied Studies, SAMHSA, July 2004.

13 See note 11.

14 See note 10.

15 Office of National Drug Control Policy. *Fact Sheet: Rohypnol*. Rockville, MD: Drug Policy Information Clearinghouse, February 2003, p. 1. www.whitehousedrugpolicy.gov/publications/factsht/rohypnol/rohypnol.pdf [accessed September 16, 2005].

16 See note 3, p. 43.

17 See note 3, p.43.

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19 National Institute on Drug Abuse. *NIDA InfoFacts: LSD*. Bethesda, MD: National Institutes of Health, March 2005, p. 2. www.nida.nih.gov/pdf/infofacts/LSD05.pdf [accessed September 16, 2005].

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Session 8: Families in Recovery (PowerPoint Presentation)

Overview

Goals of Session

- Help family members and people in recovery better understand substance use and recovery.
- Help family members understand how they can support recovery.

Handouts

- FE 8A—Anticipating and Preventing Relapse
- FE 8B—Relapse Justifications
- FE 8C—Avoiding Relapse Drift

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 67 through 76 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from www.kap.samhsa.gov by clicking on Products, clicking on Resource Documents & Manuals, and then clicking on the Matrix icon.

Slide 8-1—Families in Recovery

- In this session, we are going to talk about the people who are most important to you. All attendees are here because they care about a family member.

- People in recovery are here because they care enough about themselves and their families to seek treatment; family members are here because they want to offer encouragement and support.
- When a family is coping with a loved one who abuses stimulants, life can be frustrating and chaotic. The person who is using can behave self-destructively; the family members can resort to desperate measures just to cope.
- Often, it's hard for all involved to understand how they got to this point. How did things get this bad? Evaluating a situation when you are in the middle of it can be difficult.
- In this session we will look at how people become dependent on a substance and how they and their families recover from dependence. The hope is that by better understanding the processes of dependence and recovery, family members will be better able to provide support.

Slide 8-2—Who Makes Up a Family?

- It is important to think of family in the broadest possible terms.
- Family includes immediate family and extended family, friends, mentors, partners, colleagues from work—all of these people are part of your family when it comes to treatment. If someone you are close to is supportive, that person is part of your family.

Slide 8-3—What Is Addiction?

- Addiction is a complicated physical and emotional process that takes place in the brain. As a result of drug use, the brain changes and people engage in behavior that affects themselves and their families.
- Addiction is a medical disorder. It is counterproductive to recovery to think of addiction as representing a personal failing, a lack of willpower, or a moral downfall.

Slide 8-4—Development of Addiction

- The development of addiction involves two different areas of the brain: the prefrontal cortex and the limbic system.
- The prefrontal cortex is the intelligent, rational, thinking part of the brain. It is the decisionmaker, the brain's computer. The prefrontal cortex constantly directs our behavior and evaluates both the positives and negatives of any situation to make a decision.
- The limbic system is made up of smaller parts of the brain below the prefrontal cortex. The limbic system's involvement in emotion and motivation drives addiction. Each dose of a substance—especially stimulants—activates the limbic system. Eventually, the system becomes overactivated to the point where normal, rational restraints on behavior are lost.
- One way to understand the process of addiction is as a struggle between the rational part of the brain (the prefrontal cortex) and the emotional part of the brain (the limbic system).
- For most people who use meth, the rational part of their brain keeps their meth use in check at first. However, with continued use, meth's effects on the parts of the brain that govern emotion and motivation begin to override reason and clear thinking.

Slide 8-5—Development of the Craving Response

- Craving is the physical and emotional desire for a drug.
- Three separate processes converge to create a craving for a drug:
 - ♦ The cognitive process
 - ♦ Obsessive thinking
 - ♦ The conditioning process
- The cognitive process is how the rational part of the brain (the cortex) copes with substance use.
- The conditioning process is the involvement of the emotional part of the brain (the limbic system) in addiction.
- Obsessive thinking is the struggle between the rational and emotional responses to substance use.

Slide 8-6—Cognitive Process (Beginning Stages of Addiction)

- In the beginning stages of addiction, meth use occurs occasionally, often at a party or on a special occasion.
- Use gradually increases, but the rational part of the brain is in control and decides that using meth is justifiable because of the supposed benefits it provides.
- The positives seem to outweigh the negatives. The facts that meth is illegal and extra money is spent to buy it do not carry as much weight.

Slide 8-7—Cognitive Process (Disenchantment)

- The person who continues to use meth eventually becomes disenchanting, as the negative consequences of meth use clearly outweigh the positives.
- Some people are able to stop using when it becomes apparent that meth use is damaging their lives. Those who can't stop are addicted.
- A powerful hunger for meth becomes stronger than the rational part of the brain.
- The rational decision not to use and willpower are not enough to deter the craving for meth that has taken root in the emotional part of the brain. The rational, decisionmaking process is severely impaired, and the addicted brain's demands are imperative.

Slide 8-8—Conditioning Process (Mild Cravings)

- While the cognitive process is taking place in the prefrontal cortex, a parallel progression of events takes place in the limbic system of someone who is using meth. This is the conditioning process.
- Conditioning is a type of learning that occurs by association. Every time people take meth, they strengthen a mental link between the drug and its pleasurable effects. This link conditions the brain to want more meth.
- At first, meth use is so infrequent that there is no automatic response to the people, places, or situations associated with meth.
- Over time, this link becomes stronger and more general, so that not only taking meth, but thinking of things associated with the drug (money, a dealer's house, certain friends) can induce cravings for meth.

- Things that are associated with meth use and that initiate desire for the drug are called triggers.
- Craving is a desire for meth that is intensified by the activation of the brain's emotional center and by obsessive thoughts about meth use.
- Developing a craving for a substance is a process. Repeated uses of meth "build" a craving for the drug in a person's mind.
- At first, purchasing and using the drug activate the brain's emotional and motivational centers in the limbic system. This results in euphoria and physiological arousal: increased breathing and heart rate, adrenaline effects, and increased energy.
- The brain begins to form an association between meth and pleasure.

Slide 8-9—Conditioning Process (Strong Cravings)

- As the mental connection between meth and the pleasure it produces grows stronger, things other than the drug itself increasingly trigger craving, and the craving becomes stronger.
- A person who continues using meth will feel an overpowering physical response to meth in situations further and further removed from the drug itself.
- In the later stages of addiction, thinking about meth will set off powerful cravings. For a person who is dependent on meth, thinking about meth or about using meth produces a powerful arousal similar to actual effects of meth.
- Triggers initiate an automatic craving to use meth, and this feeling drives people to find and take meth.

Slide 8-10—Conditioning Process (Overpowering Cravings)

- Soon, triggers proliferate, and the mental links between the triggers and drug use become overpowering. Addiction—the loss of rational control to the emotional part of the brain—has set in.
- As the addiction becomes severe, people use either daily or in binges that are interrupted only by physical collapse.
- The rational brain is totally overwhelmed by the constant, powerful craving from the addicted brain. People who are addicted cannot be stronger than the conditioned response that has been forged in the brain. They can be only smarter.

Slide 8-11—Development of Obsessive Thinking (Early Use)

- When a person starts using meth, very little time or thought is invested in it. Meth use is just a small part of the person's life.
- If the person keeps using, decisions about whether to use, where to get money to buy drugs, and how to conceal the evidence of using begin to take more time and thought.
- These thoughts of using intrude more and more because the links formed in the emotional part of the brain between meth and enjoyment have begun to exert their influence.

Slide 8-12—Development of Obsessive Thinking (Continued Use)

- With continued use, thoughts about meth crowd out other aspects of life. For the most part, the emotional part of the brain is given over to addiction and meth dominates the person's thoughts.
- People using meth become so obsessed with meth that their relationships may begin to crumble. There is little room in their lives for a relationship with anyone or anything except meth.
- This overwhelming preoccupation does not mean that family members mean less to people than meth does. It means that the brain changes caused by meth make the desire to use meth all but irresistible.

Slide 8-13—Progressive Phases of Addiction

- Now we turn to the family members' responses as they watch the person they care about become dependent on meth. We can trace family members' responses through four progressive stages of addiction:
 - ♦ Introductory
 - ♦ Disenchantment
 - ♦ Maintenance
 - ♦ Disaster

Slide 8-14—Family Members' Response to Meth Use (Introductory Phase)

- During the introductory phase of a person's meth use, family members are probably not affected very much. They may be completely unaware of the meth use.
- Family members may see behaviors that stem from occasional meth use but not associate them with a drug problem.
- Family members may wonder why the person occasionally neglects responsibilities and fails to meet obligations.

Slide 8-15—Family Members' Response to Meth Use (Maintenance Phase)

- Often, during the maintenance phase of a person's addiction, family members realize that a problem exists and attempt to solve it.
- Family members may give financial assistance. They may make up excuses for thoughtless behavior that results from meth use. They even may try to take on all the responsibilities for earning money, taking care of the family, keeping up friendships, and maintaining the household.
- These efforts help only temporarily because the real problem is the meth use and its consequences.
- The problems continue to mount as long as the meth use continues. Family members want to help, so they pick up the slack for their loved one who is using.
- This behavior does more harm than good. It helps the person stay addicted by covering up the consequences of meth use. Such activities give the person more time, energy, and money to continue using and cover up the fact that meth use must stop.

Slide 8-16—Family Members' Response to Meth Use (Disenchantment Phase)

- By the time the person reaches the disenchantment phase of addiction, family members often are angry and have given up trying to solve the problem.
- Recognizing that none of the attempted solutions is working, family members try to ignore what is going on.
- When they are unable to avoid being confronted with the consequences of the person's behavior, family members tend to blame either the person who is using or themselves.
- The person's dependence on meth makes all members in the family feel guilty and ashamed of what is happening and of their inability to control the situation.

Slide 8-17—Family Members' Response to Meth Use (Disaster Phase)

- During the disaster phase, family members often end up separating from the person who is using to save themselves. As a result of the emotional and physical separation, family members feel a sense of failure and hopelessness.
- When family members stay with the person, they learn to behave and think in ways that preserve the peace but often are not healthy for individual or family well-being.
- Children in such an environment learn ways of behaving that can interfere with their ability to have healthy relationships later in life.

Slide 8-18—Benefits of Family Involvement

- It is important for family members to be involved in treatment. Studies show that treatment works better when at least one supportive family member is engaged in the treatment.
- Family members who participate in treatment have a better understanding of what the person in recovery is going through. They also learn about the stages of recovery so that they can anticipate the difficulties the person in recovery will face and be aware of problems that may arise.
- The person in recovery is responsible for quitting meth and working on recovery. But family members who have been interacting with the person in recovery during the progression of the drug dependence have been affected by the process and need to make changes of their own to undo the damage that has been done.
- Handout FE 8A—Anticipating and Preventing Relapse discusses family members' roles in recovery.

Slide 8-19—Stages of Recovery

- People who stop taking a substance they are dependent on usually go through predictable stages during their recovery.
- The timetable for recovery varies for each person, but the stages usually don't vary.
- Knowing that there is a pattern to recovery and knowing what to expect in each stage often provide encouragement to family members and help them better support the person in recovery.

Slide 8-20—Withdrawal

- The withdrawal stage usually lasts 1 to 2 weeks.
- During this stage, the most severe symptoms are craving and depression. Many people also experience low energy, difficulty sleeping, increased appetite, and difficulty concentrating.

Slide 8-21—Honeymoon

- The Honeymoon stage lasts about 4 weeks.
- It is characterized by increased energy, enthusiasm, and optimism.
- Many people think this is the end of the recovery process and that things will remain positive from here on. Unfortunately, the hardest part of the recovery is still to come.

Slide 8-22—The Wall

- The Wall is the hardest stage of recovery and one of the longest. It lasts about 12 to 16 weeks.
- The Wall brings with it some troublesome emotional and thinking difficulties. The optimism of the Honeymoon stage gives way to the full realization of the difficulty and sheer effort involved in recovery.
- People in recovery experience depression, irritability, difficulty concentrating, low energy, and a general loss of enthusiasm. Risk of relapse is very high during this stage.
- This stage is almost always a struggle for people in recovery, but with the support of family members and the recovery strategies they learn in treatment, clients get past the Wall.

Slide 8-23—Readjustment

- The readjustment stage is when the individual begins to adjust to an ongoing state of abstinence.
- During this stage, the Wall has been surmounted and the person in recovery and family members begin to return to a more normal lifestyle.
- During the readjustment stage and after, individual and family issues can benefit from psychotherapy and family counseling. Treatment for meth dependence often does not address issues of long-term importance.

Slide 8-24—Goals for Withdrawal

- The main goal for the person in recovery during the withdrawal stage of treatment is stopping meth use.
- In group sessions that focus on early recovery skills, the person in recovery learns specific techniques for reducing cravings and avoiding relapse.
- The person in recovery also begins to learn about the process of addiction and how drugs, such as meth, affect brain chemistry and the rest of the body.
- When the person in recovery is in the withdrawal stage of treatment, family members have one major decision to make: whether they are willing to be part of the recovery process.

- Family members will find it is easier to be involved if they view the meth use, not the person in recovery, as the problem and if the meth use is recognized as a medical condition, regardless of how it began.

Slide 8-25—Goals for the Honeymoon

- During the Honeymoon stage of recovery, people in recovery work on improving their physical health and outlook on recovery by exercising and staying active.
- People in recovery also begin to identify personal triggers and relapse justifications and to use targeted techniques to stay abstinent.
- Often, persons in recovery feel as if they are “cured” during this period. It is important for people in recovery to continue to work on their recovery and to avoid testing themselves by being around drugs.
- Family members can be very helpful during the Honeymoon stage, working with the person in recovery to support the primary goal of abstinence.
- Although family members are not responsible for the loved one's recovery, their behavior and attitudes during this time can significantly increase or decrease the chances of the person in recovery achieving and maintaining abstinence.
- Family members need to recognize and discontinue triggering interactions.

Slide 8-26—Goals for the Wall

- By the time people in recovery reach the stage known as the Wall, they have been abstinent for several months. They continue to work on maintaining abstinence by putting relapse prevention techniques they have learned into practice.
- The person in recovery also focuses on repairing relationships with family members and friends and developing support networks to cope with the problems that arise during recovery.
- The Wall can be a frustrating and difficult part of recovery. The person in recovery needs support and encouragement from many sources. Working on developing new interests and staying active also are important to recovery.
- Also important are recognizing and addressing dangerous emotions.
- While the person in recovery is in the stage known as the Wall, family members need to guard against expressing anger toward the person.
- As much as possible, family members need to move past resentment and work to support the person in recovery. Family members who are committed to this support need to begin trusting the loved one's recovery.
- Family members should relearn how to take care of themselves by beginning to return to the normal routines of life and pursuing activities that are rewarding and self-nourishing.
- It also is important at this stage to explore how family members communicate, how poor communication may have led to problems, and how communication can be improved.

- Handout FE 8B—Relapse Justifications helps family members understand how relapses can start.

Slide 8-27—Goals for Readjustment

- By the time people in recovery reach the readjustment stage of recovery, they know which behaviors they need to engage in to keep their recovery strong and which behaviors place their recovery at risk.
- The task for people in recovery during this stage—and for the rest of their lives—is to monitor their recovery, ensuring that they engage in those behaviors that will help them avoid relapse.
- Because people in recovery often will be confronted with the opportunity and desire to use, they need to be aware of those situations and thoughts that put them at risk of relapse. For this reason, they need to anticipate troublesome situations and have detailed plans for how to address them. The most important aspect of maintaining abstinence is knowing how to avoid relapse.
- During the readjustment stage, the person in recovery works on forming new, healthy relationships and on strengthening existing friendships. The person in recovery also begins to examine long-term life goals.
- When the person in recovery reaches the readjustment stage, the family has been with him or her through about 4 months of recovery. The person in recovery and the family members have learned a lot about what it takes to support the recovery and to make the family function well.
- The readjustment stage is marked by a return to a more predictable, more normal lifestyle for everyone in the family. Family members should be mindful that many of the changes they have made in their lives to offer support for recovery will need to continue and become permanent.
- It is important for family members to accept limitations of living with a person in recovery; maintain a balanced, healthy lifestyle; and avoid relapsing to former behaviors.
- Patience with the process of recovery is crucial.
- Handout FE 8C—Avoiding Relapse Drift helps family members understand how they can support the person in recovery.

Slide 8-28—Key Relapse Issues for People in Recovery

- The person in recovery and the family members need to evaluate which lifestyle and attitude changes are important for each of them individually and as a family. After this point in recovery, the person in recovery will receive less support in the form of treatment.
- Some of the support role will be taken up by 12-Step or mutual-help groups and by friends, but family members will be a major source of support for the person in recovery.
- Families need to decide which adaptations they have made during recovery should become permanent in their lives.
- When making these decisions, families should bear in mind the most common relapse issues for people recovering from meth use. All of the six issues listed on this slide may not be a problem for the person in recovery, but the family needs to find out which issues might be troublesome for the person in recovery.

- Family members should have an open discussion with the person in recovery about how best to support his or her recovery.

Slide 8-29—Key Relapse Issues for Family Members

- Whereas the person in recovery needs to be on the alert for relapse to meth use, family members need to be careful not to return to their former ways of behaving, thinking, and communicating.
- This slide lists common problems that can precede a slip back into old behaviors for family members.
- Just as it helps people in recovery to anticipate situations that might lead to relapse, so it will help family members to be on guard for ways in which they might slip back into behaviors that will destroy recovery and the family.

Session 9: Rebuilding Trust (Multifamily Group Discussion)

Goals of Session

- Provide an opportunity for participants to think about and discuss the role that trust plays in relationships.
- Provide an opportunity for participants to address the loss of trust that can come from stimulant use, including family members' ongoing suspicions of substance use by clients.
- Provide an opportunity for participants to begin to repair damaged relationships.

Handout

- FE 9—Rebuilding Trust

Introduction (2–3 minutes)

The counselor explains that today's session provides an opportunity for participants to discuss the loss of trust that can come with stimulant use and ways to rebuild that trust in family relationships.

Handout Review (15–20 minutes)

The counselor

- Gives participants a copy of handout FE 9—Rebuilding Trust and asks them to read the information and carefully consider and write down their answers to the questions
- Tells participants that their answers to the questions are to guide discussion; no one will see their responses

Focused Discussion (50–55 minutes)

The counselor facilitates discussion, using the questions on the handout to provide structure.

Summary (2–3 minutes)

The counselor summarizes the ideas for rebuilding trust among family members that were discussed by the group.

Open Discussion (15 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Session 10: Marijuana (PowerPoint Presentation)

Overview

Goals of Session

- Familiarize participants with the nature and prevalence of marijuana use.
- Familiarize participants with the dangers to health and to recovery posed by marijuana use.

Handout

- FE 10—Fact Sheet: Marijuana

PowerPoint Presentation (40–45 minutes)

The counselor presents the PowerPoint slides, encouraging participants to ask questions at any time. Pages 78 through 82 contain talking points for each slide. The counselor should add examples and explain concepts in a way that is appropriate for the audience.

Focused Discussion (30 minutes)

The counselor facilitates discussion of the material presented and asks open-ended questions such as

- What did you hear that was new information? What surprised you?
- How does the information relate to your experience?
- How will this information affect the way your family copes with recovery?
- What questions do you have about this information?

Open Discussion (15–20 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Presentation

The bulleted points presented below concisely state the information the counselor should cover for each slide. The PowerPoint slides can be downloaded from www.kap.samhsa.gov by clicking on Products, clicking on Resource Documents & Manuals, and then clicking on the Matrix icon.

Slide 10-1—Marijuana

- This presentation offers an overview of marijuana, including what it is, the short- and long-term effects its use has on the mind and body, and the risks it poses to recovery.

Slide 10-2—The Importance of Total Abstinence

- For treatment to work, people in recovery should be totally abstinent. This means that regardless of why people are in treatment, they should abstain from *all* psychoactive substances.

- A person in treatment for abusing stimulants must give up alcohol and all illegal drugs, even drugs such as marijuana that many people believe are harmless, to ensure a successful recovery.
- The use of any substance can jeopardize recovery from stimulant dependence.

Slide 10-3—Is Marijuana Harmless?

- Many people wrongly believe that marijuana is not dangerous, especially when compared with drugs such as heroin, cocaine, crack, meth, or club drugs.
- Marijuana is the most widely used illegal drug, which may contribute to the perception that it is harmless. Each year, about 25 million Americans ages 12 and older use marijuana. That is more than 1 out of every 10 Americans.¹
- More young people go into treatment for marijuana use than for all other illegal drug use combined.²
- Marijuana use poses significant health hazards. It affects nearly every organ system in the body.³
- In addition to its physical effects, marijuana can have a profound impact on people's education, employment, and personal life.

Slide 10-4—Marijuana Prevalence

- Each year about 2.6 million people try marijuana for the first time. Two-thirds of those first-time users are younger than 18. The average age when people first try marijuana is 17.⁴
- Two out of every five Americans have tried marijuana. One in ten has used marijuana in the last year. One in a hundred has used marijuana at least 300 days in the last year.⁵

Slide 10-5—What Is Marijuana?

- Marijuana is a greenish gray mixture of dried and shredded parts of the hemp plant, *Cannabis sativa*. The mixture may consist of leaves, stems, flowers, and seeds.
- It is usually smoked in hand-rolled cigarettes or pipes. Sometimes cigars are sliced open, and the tobacco inside is replaced with marijuana.
- Marijuana's more concentrated forms are a resin called hashish and a black liquid called hash oil.

Slide 10-6—Street Names

- Marijuana is known by many street names that vary by region of the United States. Some of the more common names are pot, weed, bud, herb, ganja, hash, grass, Mary Jane, chronic, and cannabis.
- Marijuana cigarettes are known as joints or nails. Pipes are called bongs. Cigars packed with marijuana are called blunts.

Slide 10-7—History

- Marijuana is grown in all 50 States. The main foreign sources for marijuana are Mexico, Canada, Colombia, and Jamaica.

- Marijuana is a Schedule I controlled substance, like heroin and LSD.
- Nonmedical use of marijuana has been illegal in the United States since 1937.

Slide 10-8—Medical Marijuana

- Marijuana has been used to treat
 - ♦ Loss of vision due to glaucoma
 - ♦ Nausea experienced by patients receiving treatment for HIV/AIDS and cancer
 - ♦ Pain associated with the multiple sclerosis
- In 1985, the U.S. Food and Drug Administration approved Marinol, an oral capsule that includes marijuana's active ingredient.
- Marinol is available by prescription to treat the nausea and vomiting that can accompany cancer chemotherapy and the weight loss seen in patients with AIDS.
- Other countries, including Canada and the United Kingdom, have approved an aerosol form of marijuana that is delivered with an inhaler to treat pain in patients who have multiple sclerosis.

Slide 10-9—Active Ingredient

- The active ingredient in marijuana is the delta-9-tetrahydrocannabinol (THC).
- THC is responsible for the effects that produce the marijuana high.
- Over the past two decades, THC levels in marijuana have increased. Today's marijuana contains three times as much THC as marijuana from the 1970s and 1980s, making it three times stronger.

Slide 10-10—Short-Term Effects

- When someone smokes marijuana, THC rapidly goes from the lungs to the bloodstream to the brain. THC causes nerve cells in the brain to release the neurotransmitter dopamine.
- The release of dopamine is responsible for the person feeling "high," a relaxed, euphoric feeling.
- THC can also impair short-term memory, disrupt balance and coordination, slow reaction time, increase heart rate, distort perception, and result in disorientation, confusion, and panic.
- The immediate effects of marijuana can last from 1 to 3 hours.
- After the high subsides, a person may feel sleepy or depressed. Feelings of panic, anxiety, and distrust are common.

Slide 10-11—Long-Term Effects

- Marijuana can have long-term effects on memory and learning.
- People who use marijuana regularly have trouble learning and remembering even 30 days after they stop using the drug.⁶

- Students who smoke marijuana regularly get lower grades in high school and college than those who don't.⁷
- Marijuana impairs so many skills that influence learning that people who use it regularly may be functioning at a reduced intellectual level all of the time.
- Workers who use marijuana are more likely than their colleagues to have problems on the job, including accidents, absence, lateness, and job loss.⁸
- People who use marijuana at least 300 days a year are more likely to be unemployed than those who use it less often or not at all.⁹

Slide 10-12—Cancer Risks

- People who smoke marijuana are exposed to lung damage just as people who smoke tobacco.¹⁰
- Regular use of marijuana can cause frequent chest colds, bronchitis, and emphysema.¹¹
- Marijuana smoke has five times more tar and carbon monoxide and up to 70 percent more carcinogens than does tobacco smoke.¹²
- Smoking marijuana may increase the risk of lung cancer more than does smoking tobacco.¹³
- Studies suggest that smoking marijuana increases the chances of developing cancer of the head or neck.¹⁴

Slide 10-13—Risk of Infection and Disease

- The active ingredient in marijuana, THC, hampers the immune system's ability to fight off infection and disease.
- Studies have shown that immune system cells exposed to marijuana ingredients have a reduced ability to prevent infections and tumors.¹⁵

Slide 10-14—Marijuana and Driving

- Because it impairs balance, coordination, and decisionmaking, marijuana is associated with all kinds of accidents.
- Studies show that up to 11 percent of fatal accident victims have THC in their bodies.¹⁶
- Driving under the influence of marijuana is dangerous.
- Even low doses of marijuana significantly reduce drivers' performance on road tests. Combining marijuana with alcohol further impairs drivers' abilities.¹⁷
- Drivers' coordination and reaction time are impaired for several hours after the high from marijuana use has faded.
- After alcohol, marijuana is the substance most frequently found in drivers involved in fatal car crashes. Seven percent of fatal crashes involve marijuana.¹⁸
- Studies estimate that more than one in seven high school seniors drive under the influence of marijuana.¹⁹

Slide 10-15—Marijuana and Pregnancy

- A woman who uses marijuana during pregnancy exposes her fetus to a variety of dangers.
- Low birth weight and problems with neurological development have been linked to marijuana use.
- Later in life, babies exposed to marijuana during pregnancy may have trouble concentrating, learning, and making decisions. These problems are compounded if the mother continues to use marijuana after the child is born.
- Breast-feeding mothers who use marijuana can pass THC to their babies. THC in breast milk is very concentrated and has been linked to problems with motor development in children.

Slide 10-16—Marijuana Addiction

- One of the reasons people think of marijuana as a “safe” drug is that they think it is not addictive.
- Although people may not develop physical dependence on marijuana, they can become psychologically addicted to marijuana. They cannot imagine living without the drug.
- Addiction means using a drug even though it interferes with family, school, work, and other important aspects of life.
- For those who are psychologically addicted, withdrawal from marijuana use can include cravings for the drug, anxiety, irritability, and sleeplessness.

Slide 10-17—Marijuana and Other Drugs

- People who use marijuana at least 300 days a year are more likely to drink heavily and use illicit drugs than people who occasionally use marijuana or those who never use it.²⁰
- The younger people are when they start using marijuana, the more likely they are to use heroin and cocaine and become dependent on drugs as adults.²¹
- Because it is so integrally linked with other substance use, marijuana use poses a particular risk to people in recovery from meth use.

Slide 10-18—Marijuana and Relapse

- Research suggests that people recovering from cocaine or meth use who continue to use marijuana have relapse rates two to three times higher than people who abstain from marijuana.²²

Slide 10-19—Marijuana and Families

- People may use marijuana as a way to cope with boredom, anxiety, and depression.
- Marijuana can be used to escape, rather than address, serious problems in a family.
- In addition to making recovery from meth harder, marijuana use can contribute to the deterioration of personal and family life.
- More than half of adult men who are arrested used marijuana in the past year. Two out of five men who are arrested test positive for marijuana at the time of their arrest.

1 Substance Abuse and Mental Health Services Administration (SAMHSA). *The NSDUH Report: Daily Marijuana Users*. Rockville, MD: Office of Applied Studies, SAMHSA, November 26, 2004. www.oas.samhsa.gov/2k4/dailyMJ/dailyMJ.htm [accessed September 16, 2005].

2 Office of National Drug Control Policy. *Fact Sheet: Marijuana*. Rockville, MD: Drug Policy Information Clearinghouse, February 2004, p. 6. www.whitehousedrugpolicy.gov/publications/pdf/ncj198099.pdf [accessed September 16, 2005].

3 Khalsa, J.H.; Genser, S.; Francis, H.; and Martin, B. Clinical consequences of marijuana. *Journal of Clinical Pharmacology* 42 (suppl):7S–10S, 2002.

4 See note 2, p. 1.

5 See note 2.

6 Center for Substance Abuse Prevention. *Marijuana: Weeding Out the Hype*. DHHS Publication No. (SMA) 3710D. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2002, p. 13.

7 National Institute on Drug Abuse. *NIDA InfoFacts: Marijuana*. Bethesda, MD: National Institutes of Health, March 2004, p. 4. www.drugabuse.gov/PDF/InfoFacts/Marijuana04.pdf [accessed September 16, 2005].

8 See note 7.

9 See note 1.

10 See note 2, p. 3.

11 See note 2, p. 3.

12 See note 7, p. 3.

13 See note 7, p. 3.

14 See note 7, p. 3.

15 See note 7, p. 3.

16 National Institute on Drug Abuse. *Research Report Series: Marijuana Abuse*. NIH Publication No. 02-3859. Bethesda, MD: National Institutes of Health, October 2002, p. 4. www.drugabuse.gov/PDF/RRMarijuana.pdf [accessed September 16, 2005].

17 See note 7, pp. 3, 4.

18 See note 6, p. 19.

19 See note 2, p. 4.

20 See note 1.

21 See note 2, p. 1.

22 Rawson, R.A.; Shoptaw, S.J.; Obert, J.L.; McCann, M.J.; Hasson, A.L.; Marinelli-Casey, P.J.; Brethen, P.R.; and Ling, W. An intensive outpatient approach for cocaine abuse treatment: The Matrix model. *Journal of Substance Abuse Treatment* 12(2):121, 1995.

Session 11: Living With an Addiction (Multifamily Group Discussion)

Goals of Session

- Provide an opportunity for participants to think about and discuss the ways in which recovering from addiction will affect family life.
- Provide an opportunity for participants to share concerns and solutions with others in the group.

Handout

- FE 11—Living With an Addiction

Introduction (2–3 minutes)

The counselor explains that

- Making a commitment to recovery requires recognizing and accepting certain realities.
- Recovery brings all sorts of questions: What happens after the drug and alcohol use stops? Does life eventually go back to normal? Can a person in recovery lead the same lifestyle as a person who has never been addicted?
- Today's session provides an opportunity for participants to discuss issues and concerns related to living with addiction and recovery from the perspectives of both people in recovery and their family members.

Handout Review (10–15 minutes)

The counselor

- Asks participants to read the information on the handout and carefully consider and write down their answers to the questions
- Tells participants that their answers to the questions are to guide discussion; no one will see their responses

Focused Discussion (50–55 minutes)

The counselor facilitates discussion, using the questions on the handout to provide structure.

Summary (2–3 minutes)

The counselor summarizes the issues and ideas for effectively living with addiction and recovery that were discussed by the group.

Open Discussion (15 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Session 12: Communication Traps (Multifamily Group Discussion)

Goals of Session

- Provide information about communication styles, techniques, and traps.
- Provide an opportunity for participants to consider and discuss family communication issues.
- Encourage participants to practice new communication skills.

Handouts

- FE 12A—Communication Traps
- FE 12B—Improving Communication
- FE 12C—Contract: Commitment To Practice Communication Skills

Introduction (2–3 minutes)

The counselor explains that

- People in families coping with substance use disorders often feel guilty, angry, hurt, and defensive.
- These feelings can affect seriously the way family members communicate with one another; negative patterns of interacting often become automatic.
- Understanding that positive communication involves skills that can be *learned* is an important first step in improving family relationships.
- This session focuses on communication traps (communication behaviors that are not productive) and the skills necessary for improving family communication.
- Paying attention to communication issues and learning new skills help families improve their communication.
- Clear, positive interactions allow people to increase self-esteem and confidence and pave the road to committed, trusting relationships.
- Recovery from substance use disorders is a difficult process for both the person in recovery and his or her family.
- Positive and trusting family relationships support *everyone* in the recovery process.

Focused Discussion and Handout Review (55–60 minutes)

The counselor facilitates discussion of communication and recovery by asking participants the following questions:

- In what ways do you think improving communication could improve your family relationships?
- In what ways has communication in your family changed during recovery?

The counselor

- Gives participants a copy of FE 12A—Communication Traps
- Provides examples of each communication trap (one example for each communication trap is provided in Communication Traps: Sample Scenarios on pages 87 and 88; the counselor may want to add examples)
- Facilitates discussion of each communication trap, asking questions such as
 - ♦ How do you think the situation in the example could have been avoided?
 - ♦ Do you recognize this communication trap from your own family interaction? Would you be willing to share an example?
- Provides examples of positive “fixes” for each communication trap if they were not brought up in discussion (one example for each communication trap is provided in Communication Traps: Sample Scenarios; the counselor may want to add examples)

After discussion of FE 12A—Communication Traps, the counselor

- Gives participants a copy of FE 12B—Improving Communication
- Goes over each point

Summary (15 minutes)

The counselor

- Summarizes the issues and ideas related to communication in recovering families that were discussed by the group
- Gives participants handout FE 12C—Contract: Commitment To Practice Communication Skills and allows about 5 minutes for participants to complete the contract using the techniques listed on FE 12B
- Suggests that participants keep the contract in a place that will remind them to practice these skills regularly

Open Discussion (15 minutes)

The counselor allows time for participants to ask general questions and to bring up any pressing issues they may have.

Communication Traps: Sample Scenarios

1. Are You Assuming?

The scenario

Nancy asked her husband Pete, “Will you be coming home right after work?” Pete exploded, “You don’t have to check up on me every 5 minutes! Do you want a urine sample, too?” Nancy responded angrily, “Well, you’ve sure given me enough reasons to check up on you.” The conversation then became a full-fledged fight about the past. Pete assumed that Nancy was suspicious when she asked whether he was coming right home from work and felt frustrated and angry that she wasn’t trusting him or noticing the changes he’d made in recovery. What Nancy was really wondering when she asked the question was whether Pete would be able to pick up the dry cleaning before the shop closed or whether she needed to make plans to leave work early.

Example of a communication “fix”

Pete could have avoided the fight by not assuming that he knew what Nancy was thinking. He could have answered, “Yes, why do you ask?” in a neutral tone of voice or answered directly and waited for her response.

2. Are You Hinting?

The scenario

Ricardo, a 17-year-old in recovery, was playing a video game when his mother, Rosa, walked by and said, “Ricardo, the kitchen trash can is getting full.” Ricardo responded, “Uh huh,” and continued to play his game. Half an hour later, Rosa noticed that Ricardo hadn’t emptied the trash. She angrily confronted Ricardo for not taking the trash out right away. Ricardo responded to her anger by loudly saying, “Hey, I’ll do it when I’m good and ready!”

Example of a communication “fix”

Instead of hinting that she wanted Ricardo to take out the trash right away, she could have asked him directly by saying, “Ricardo, I need you to take out the trash in the next 15 minutes; I’ll be starting dinner soon and will have a lot of vegetable scraps.” Ricardo would then have known that she meant “now” and not “sometime.”

3. Are You Giving Double Messages?

The scenario

Tanya asked her husband, Andre, “Do you mind if I go fishing with Sharonne Saturday?” Andre had been planning to spend time with Tanya on the weekend and didn’t want her to go with Sharonne. However, he replied “Sure, go ahead.” As he said this, his arms were stiffly crossed across his chest and he didn’t look directly at Tanya. Tanya felt uneasy and said, “You’re really OK with it?” Andre responded angrily, “I said I was, didn’t I?” The discussion escalated into an argument.

Example of a communication “fix”

Andre could have been honest with Tanya about his feelings, instead of showing them indirectly. He could have said, “Well, I was hoping we could spend some time together Saturday. I’ve been working too much and I miss seeing you.” Tanya would then have understood clearly what his needs were and either changed her plans or negotiated a way to spend time with him.

4. Can You Admit a Mistake?

The scenario

Bob forgot that it was his and Catherine’s fifth wedding anniversary. A coworker invited him to bowl a few frames after work, and he accepted. When he arrived home, he discovered the table set for two and Catherine in tears. She had left their children with her sister and prepared a romantic dinner, now drying out in the oven. When she confronted Bob about being so late, he responded defensively, “You know I have trouble remembering these things; you should have reminded me! How am I supposed to know you were planning a special dinner?” Catherine responded, “How could you forget our anniversary?” Bob was feeling guilty at this point, but not wanting to admit he was wrong, defensively replied, “Listen, Catherine, we’ve been married 5 years now; what’s the big deal?” Catherine locked herself in the bedroom.

Example of a communication “fix”

When Bob realized that he had forgotten their anniversary, he could have simply admitted his mistake and apologized sincerely. Although the ensuing discussion still would have been difficult, it may not have escalated.

5. Do You Use “I” Statements?

The scenario

Pam, a senior in high school, was out on a date. Her curfew was midnight, and she was rarely late. When Pam arrived home at 1 a.m., her mother, Emily, was extremely worried. Emily greeted Pam at the door saying, “You’re late! You could have picked up a phone and called; you’re always so inconsiderate!” Pam responded angrily, “I am not always inconsiderate!” A fight ensued.

Example of a communication “fix”

Emily could have used an “I” statement, saying something like “I really worry that something has happened when you’re late and I don’t hear from you. Please give me a quick call if you’ll be late.” Emily would have directly addressed an important issue in a calm way, and Pam would not have felt the need to defend herself aggressively. Pam also may be more likely to call her mother the next time she is late.